

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the changes made shown on G 110 7/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03873 96

1. PLACE OF DEATH

County St. Louis
City or town Post Office Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 1 year
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Louis
City or town Post Office Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1324
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Alexander Arons

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1887

8. AGE: 59 Years 10 Months 15 Days 11 less than one day
hrs. min.

9. Birthplace Prussia
(Town, county, and state)

10. Usual occupation REAL ESTATE

11. Industry or business

12. Name Solomon Arons

13. Birthplace Prussia

14. Maiden name Solomon Louis

15. Birthplace Prussia

16. Informant not known

Address

17. Removal Removal Date thereof 6-5-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Harry Nieberg & Son

Location 141 Ludlow St., New York City

18. Funeral director Lee C. Patterson & Son

Address Prussia, Md.

19. June 5, 1947 Irma E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47, at 642 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

DURATION

Mutilated
Body
air plane accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, homicide Accident Date of 5/30-47
Where did injury occur? Post Office Rural (City or town) (County) (State)

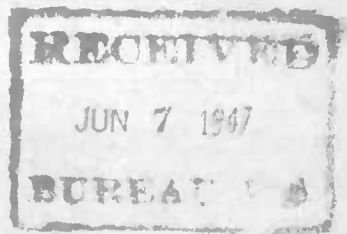
Injured at home, farm, industry, public place (where?) Public Carrier

Means of injury Airplane Injured at work?

Medical Examiner W. D. ...
for Cecil County
M. D. or other

23. SIGNATURE W. D. ... Address Prussia, Md. Date signed 6-4-47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death See Deed Land
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alberta Bauch

3. (b) Social Security Number

E107

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

Sheldon H. Bauch

7. Birth date of deceased (mo., day, yr.)

May 14 1927

8. AGE:

Years

Months

Days

If less than one day

2016

hrs.

min.

9. Birthplace

Atlantic City, N.J.
(Town, county, and state)

10. Usual occupation

See

11. Industry or business

12. Name

Samuel Gold

13. Birthplace

Philadelphia, Pa.

14. Maiden name

Helene Gold

15. Birthplace

Canada

16. Informant

Eugene Smith

Address

Port Orange N.J.

17. Removal

(Burial, cremation, or removal, Which?)

Date thereof

6-3-47

(month) (day) (year)

18. Name of funeral home

Philip Anter & Son

Location

Newark, New Jersey

19. Funeral director

See A. Patterson

Address

Perryville, Md.

19. Date rec'd by registrar

June 3 1947June E. Daugherty

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.J. County Essex
 City or town Port Orange
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 251 N. Center St.
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947, at 6426

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....
 and that I last saw him alive on19.....

Immediate cause of death

Disturbance of body

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30/47
 Where did injury occur? Port Deposit, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

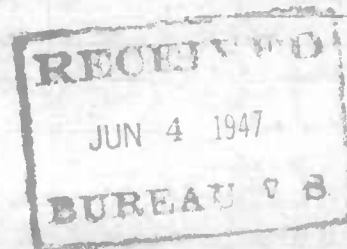
Carry case

Injured at work?

23. SIGNATURE

R. L. Dockson Medical Examiner
James E. Daugherty M. D. or other
 Address Perryville, Md. Date signed 5/31-47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03874 96

1. PLACE OF DEATH:

County Cecil
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Sudden Landing
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State N. J. County Essex
 City or town Franklin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 251 N. Center St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sheldon H Bauch

3. (b) Social Security Number

4. Sex M. 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Alberta Bauch

7. Birth date of deceased (mo., day, yr.) Aug 6 1924 8. (c) If alive, give age 20 years

8. AGE: Years 20 Months 10 Days 24 It less than one day hrs. min.

9. Birthplace Newark N.J.
 (Town, county, and state)

10. Usual occupation Restaurant

11. Industry or business

12. Name Karl C Bauch

13. Birthplace New York City

14. Maiden name Ida Pinkowsky

15. Birthplace New York City

16. Informant Eugene M. Bauch

Address Franklin N.J.

17. Removal Philip Apter & Son Date thereof 6-3-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Location Newark, New Jersey

18. Funeral director Lee A. Patterson & Son

Address Lynchville, Md.

19. June 3 19 47 James E. Dugan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? Port Deposit Cecil Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Carriage

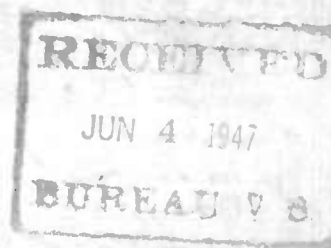
Means of injury Aeroplane Injured at work?

Signature Sheldon Bauch Medical Examiner Cecil County

Address Franklin Md M. D. or other _____

Date signed June 3 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Patuxent Rural
 City or town Patuxent Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Sudden Landing
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State N.Y. County Putnam
 City or town Flushing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 139-19 34th St Flushing N.Y.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Eileen Margaret Bendgumas

3.(b) Social Security Number

ED 74. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Frances J Bendgumas6.(c) If alive, give age 23 years7. Birth date of deceased (mo., day, year) May 16 - 19218. AGE: Years 26 Months 0 Days 14 It less than one day hrs. min.9. Birthplace Brooklyn N.Y.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Edward Kent13. Birthplace Jersey City N.J.14. Maiden name Helen Kent15. Birthplace New York N.Y.16. Informant Frances J BendgumasAddress 12 Navy Panama17. Removal 6-4-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fairchild Sons Inc.Location Flushing L.I. N.Y.18. Funeral director Lee B Patterson & SonAddress Greenville, Md19. June 4 1947 Drew E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 6:42 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw h..... alive on19.....

Immediate cause of death..... DURATION

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JUN 6 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03877 96

1. PLACE OF DEATH

County Cecil
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death Sudden
Hospital, institution, or street address where death occurred: Sudden

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Piddlesex
City or town Woodbridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 31 Martin Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Bernstein

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mildred Bernstein

7. Birth date of deceased (mo., day, yr.) June 12, 1907

8. AGE: Years 39 Months 11 Days 19 It less than one day

9. Birthplace Baltimore Pa.
(Town, county, and state)

10. Usual occupation Auto Dealer

11. Industry or business

12. Name Harry Bernstein

13. Birthplace Hagerstown

14. Maiden name Kate Anthonity

15. Birthplace Annetta

16. Informant Nathan Bernstein

Address 8 E Queen St Woodbridge

17. Removal June 1947
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Greiner Funeral Home

Location Woodbridge, N J

18. Funeral director Eva Patterson & Son

Address Perryville, Md.

19. June 4, 1947 June E. Dougherty

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 6420

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death Institution of body
Due to
Due to Airplane Acc.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 5/30-47

Where did injury occur Port Deposit Cecil Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where) Public Center

Means of injury Airplane injured at work?

Medical Examiner

23. SIGNATURE R. D. Doolson M.D.
Address Perryville, Md. M. D. or other

Date signed 5-1-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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JUN 6 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 days
 Hospital, institution, or street address where death occurred:
Veterans Administration
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Funkstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war Spanish-American

3. (a) FULL NAME

BRADY, ERNEST H.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. Bertha Brady
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 19, 1872
 8. AGE: Years 75 Months 0 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore County, Md.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business _____
 FATHER 12. Name Unknown
 13. Birthplace Unknown
 MOTHER 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Hospital Records
 Address Veterans Administration, Perry Point, Md.
 17. Removal Date thereof May 17, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven
 Location Hagerstown, Md.
 18. Funeral director L. H. Richer
 Address Funkstown Md.
 19. 5/17 19 47 James E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 47 2:55 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 19 47 to May 17 19 47
 and that I last saw him alive on May 17 19 47

Immediate cause of death _____ DURATION
Cerebral Hemorrhage 1 day
Uremia 1 day
 Due to Generalized Arteriosclerosis 10 yr.
 Due to _____
 Other conditions Psychosis with Cerebral
Arteriosclerosis 4 Mos.
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE A. E. Trollinger
A. E. TROLLINGER, M.D., Clinical Director
 Address Veterans Administration Date signed 5/17/47
Perry Point, Md.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

Reg. Dist. No. 03879 96

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Country: England xxx #2 Myton Gates City or town: Milby Boro Bridge, Yorkshire (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME Harold Burgess				3. (b) Social Security Number 809			
4. Sex M		5. Color or Race White		6. (a) Single, married, widowed, or divorced Divorced (?)		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife Unknown				20. DATE OF DEATH May 30 1947 at 6:42 P.M.			
7. Birth date of deceased (mo., day, yr.) May 1, 1918				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19....., 10....., 19..... and that I last saw him..... alive on..... 19.....			
8. AGE: Years 29 Months 0 Days 29		If less than one day..... hrs. min.		Immediate cause of death Mutilated Body.		DURATION	
9. Birthplace #2 Myton Gates, Milby Borough Bridge, Yorkshire, England (Town, county, and country)				Due to..... Airplane		Due to.....	
10. Usual occupation				Other conditions.....		(Include pregnancy within 3 months of death)	
11. Industry or business				Major findings of operations.....		Date of op.	
FATHER		12. Name Claude H. Burgess		Autopsy results.....		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
MOTHER		13. Birthplace Stourton, England		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of 5/30-47		Where did injury occur? Port Deposit civil ind. (City or town) (County) (State)	
14. Maiden name Clara Marshall		15. Birthplace Leeds, England		Injured at home, farm, industry, public place (where?).....		Means of injury Airplane Injured at work?	
16. Informant #2 Myton Gates, Milby Borough Bridge, Yorkshire, England		17. Removal Date thereof 6-12-47 (Burial, cremation, or removal. Which?) Cemetery or crematory #2 Myton Gates, Milby Boro Bridge, Yorkshire, England (via NYC)		Location.....		Medical Examiner Dr. Cecil County	
18. Funeral director Lee A. Patterson & Son Address Perryville, Md.		19. Date rec'd by registrar June 12 1947		Registrar James E. Daugherty		Address..... Date signed 6-5-47	

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RECEIVED

JUN 14 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County St. Louis
City or town St. Louis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sudden Landing
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)
State Mo. County St. Louis
City or town St. Louis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4943 Lindell Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Francis Byrne

3. (b) Social Security Number

168-03-5075

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 3, 1899 6. (c) If alive, give age 20 years

8. AGE: 48 Years 1 Months 1 Days 1 hr. 1 min.

9. Birthplace Chicago, Ill.
(Town, county, and state)

10. Usual occupation Fire Chief Roppers Co

11. Industry or business Fire Chief Roppers Co

12. Name John Francis Byrne

13. Birthplace Wilmington, Ireland

14. Maiden name Agnes Smith

15. Birthplace Chicago, Ill.

16. Informant Carl D. Wimmer

Address Roppers Co in Pittsburg

17. Removal Removal Date thereof 6-3-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Funeral Home Kampp Funeral Home

Location Chicago, Ill.

18. Funeral director Lee A. Patterson & Son

Address Ameryville, Md.

19. June 3 19 47 Irving E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47, at 642 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19

Immediate cause of death Mutilation of body DURATION

Due to Aviation Accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Ante-mortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur St. Louis, Mo.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Aviation Injured at work?

Medical Examiner Dr. W. D. Wimmer for Cecil County

23. SIGNATURE Irving E. Daugherty M. D. or other

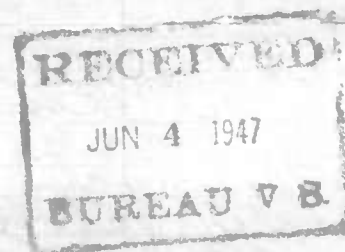
Address St. Louis, Mo. Date signed 6-1-47

MARGIN RESERVED FOR BINDING

VS A15

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 03881

1. PLACE OF DEATH
 County Cecil
 City or town Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Charles Edward Cartz

3. (b) Social Security Number
197-16-3936

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary Elizabeth
 7. Birth date of deceased (mo., day, yr.) May-24-1869
 8. AGE: Years 78 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Blacksmith
 11. Industry or business _____
 FATHER 12. Name Edward Cartz
 13. Birthplace Maryland
 MOTHER 14. Maiden name Sarah Allen
 15. Birthplace Maryland

16. Informant Mrs. George E. Cartz
 Address Elkton, Maryland
 17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof May 31-47
 (month) (day) (year)
 Cemetery or crematory Delthel Chesapeake City
 Location Chesapeake City
 19. Funeral director H.W. Lippman
 Address Elkton, Md.

19. May 24 1947 John B. H. H. H.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 57-4-47 at 3 30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940 to May 24 1947
 and that I last saw him alive on May 24 1947
 Immediate cause of death Acute Corbain
Heart
 Due to Chronic Hypertension
Cardiomegaly, senile
 Due to _____
 Other conditions _____

DURATION

15 months7 years

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Thos. J. Doms md
 Address Chesapeake City, Md. M. D. or other _____
 Date signed 5/26/47

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

STATE OF MISSISSIPPI

DEATH

DEATH

RECEIVED

MAY 27 1947

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03882

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH

County.....*St. Louis Rural*.....
 City or town.....*Sudden Landing*.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death.....
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*N.Y.*..... County.....
 City or town.....*New York*.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*612 Perry St. N.Y.*.....
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (a) FULL NAME

Jermey Chrysler

3. (b) Social Security Number

207

4. Sex

M.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Mr 17 1898*
 6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*49**5**11*

hrs.

min.

9. Birthplace

Brooklyn. N.Y.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-6-47

(month) (day) (year)

Cemetery or crematory

Coughlin Funeral Home

Location

1970 Broadway, New York City

18. Funeral director

Address

19.

June 6, 1947

(Date rec'd by registrar)

Jane E. Dougherty

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*May 30*..... 19*47*.....*6:42 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed.....

6-5-47

11

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JUN 9 1947
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45C

03883 94

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Cecil

City or town..... Charlestown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 1/2 hr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Cecil

City or town..... Charlestown
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William B Clayton

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Married

8.(b) Name of husband or wife..... Dennis Clayton

6.(c) If alive, give age..... 63 years

7. Birth date of deceased (mo., day, yr.)..... April 5 1879

8. AGE: Years 68 1/2 Months 25 Days 25 hrs. min.

9. Birthplace..... Charlestown Md
(Town, county, and state)

10. Usual occupation..... Mail Carrier

11. Industry or business.....

12. Name..... David Clayton

13. Birthplace..... Md

14. Maiden name..... Ella Marshall

15. Birthplace..... Md

16. Informant..... Mrs William B Clayton

Address..... Charlestown Md

17..... Burial Date thereof..... 6-2-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Charlestown Mt. Zion

Location..... Charlestown Md

18. Funeral director..... Joseph A. Grant

Address..... North East Md

19..... 6-1-47 Lida K. Curran
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

D.S.T.

20. DATE OF DEATH..... 30 May 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1946 to 30 May 1947 and that I last saw him alive on 29 May 1947

Immediate cause of death..... Adenocarcinoma of mouth with metastasis DURATION 1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Klaus H. Huebner M.D.

Address..... North East Md Date signed..... 30 May 47

MARGIN RESERVED FOR BINDING

VS-A15 S-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 4 1947
BUREAU 'B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03884

1. PLACE OF DEATH:

County Cecil
City or town Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 years
Hospital, institution, or street address where death occurred
221 Howard St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Cecil
City or town Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 221 Howard St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Dora L. Cleaves

3. (b) Social Security Number

4. Sex F. 5. Color or race Wh 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Henry M. Cleaves

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Jan 28 1865

8. AGE: Years 82 Months 4 Days 0 If less than one day hrs. min.

9. Birthplace Bloomington Pa
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name William Wernick

13. Birthplace Pa

14. Maiden name Anna Jane Spangston

15. Birthplace Pa

16. Informant Mrs. Frances Cleaves

Address 221 Howard St Elkton, Md

17. Burial Date thereof May 31, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md

18. Funeral director H. W. Rippe

Address Elkton Md.

19. May 31 1947 J. R. Frazer
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 25 to May 28 1947
and that I last saw him alive on May 27 1947

Immediate cause of death Cerebral Embolism DURATION 5 min

Due to Chronic Endocarditis

Due to

Other conditions Chronic Interstitial Nephritis, Arteriosclerosis, general

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Heber Bates, M.D. M. D. or other

Address Elkton Md Date signed 5/28/47

MARGIN RESERVED FOR BINDING

VS A15 945:5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 3 1947

BUREAU L S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*statement of STEWART & MOWEN by telephone 6-5-47. L
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173

03885

Reg. Dist. No. 96

1. PLACE OF DEATH:

County... Prince George's Rural
City or town... Walden Landing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death...
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Fla. County... Dade
City or town... Miami
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2(a) If veteran, name war... World War II ✓

3. (a) FULL NAME

Wm. Eritt Coney

3. (b) Social Security Number

EA07

4. Sex... M 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Married
6. (b) Name of husband or wife... Louise Henry Coney

7. Birth date of deceased (mo., day, yr.)... March 29 1906 6. (c) If alive, give age... 3 1/2 years

8. AGE: Years... 41 Months... 2 Days... 1 If less than one day... hrs. min.

9. Birthplace... Baltimore Md.
(Town, county, and state)

10. Usual occupation... Animator

11. Industry or business

12. Name... William Minton Coney

13. Birthplace... Baltimore

14. Maiden name... Mabel Eritt

15. Birthplace... Baltimore Md.

16. Informant... Wm. Minton Coney

Address... 108 W. North Ave Balt

17. Burial, cremation, or removal. Which? Removal Date thereof... 6-3-47
(month) (day) (year)

18. Location... Stewart & Mowen CEMETERY: Loud
108 W. North Ave Balt. Md. Park, Balto. Md.

19. Funeral director... St. C. Patterson

Address... Pringville, Md

20. Date rec'd by registrar... June 3 1947 Registrar... James E. Dougherty

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 30 19... 47 at... 642nd M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

...19... to... 19... and that I last saw him... alive on... 19...

Immediate cause of death... Mytulated body

Due to... Acrophonolaud

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Pen and Date of... 6730-47

Where did injury occur? Post Office Cent Md (City or town) (County) (State)

Injured at home, farm, industry, public place, where? Public Carrier

Means of injury... Acrophane Injured at work?

23. SIGNATURE... Wm. Minton Coney Medical Examiner

Address... Pringville, Md M. D. or other

Date signed... 6-2-47

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BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **Cecil**
 City or town..... **Perryville, Rural, Ellerslie.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **Life**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County..... **Cecil**
 City or town..... **Perryville, Rural, Ellerslie**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph Coudon, Of H.

3. (b) Social Security Number

4. Sex..... **Male** 5. Color or race..... **White** 6.(a) Single, married, widowed, or divorced..... **Widowed**
 B.(b) Name of husband or wife..... **Clarita Dalcour Coudon**
 7. Birth date of deceased (mo., day, yr.)..... **March 11, 1860** 6.(c) If alive, give age..... years
 8. AGE: Years..... **87** Months..... **2** Days..... **19** If less than one day..... hrs. min.

9. Birthplace..... **Perryville, Cecil Co., Md.**
 (Town, county, and state)

10. Usual occupation..... **None**

11. Industry or business.....

FATHER 12. Name..... **Henry S. Coudon**
 13. Birthplace..... **Cecil Co., Md**

MOTHER 14. Maiden name..... **Martha Levering Coudon**
 15. Birthplace..... **Baltimore, Md.**

16. Informant..... **Henry F. Coudon**
 Address..... **Perryville, Md.**

17. Burial Date thereof..... **June 1, 1947**
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... **Coudon, At Ellerslie**
 Location..... **Perryville, Md. Rural**

18. Funeral director..... **L. A. Patterson & Son**
 Address..... **Perryville, Md.**

19. Date rec'd by registrar..... **June 1, 1947** Registrar..... **James E. Dougherty**

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 30, 1947** 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 10, 1947 to **May 30, 1947**
 and that I last saw him alive on **May 30, 1947**

Immediate cause of death.....
Coronary Thrombosis
 Due to.....
 Due to.....
 Other conditions..... **Cardiac Failure**
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **Charles J. Foley**
 M.D. or other

Address..... **Home & Office** Date signed..... **June 3/1947**

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JUN 3 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the
Charge under
Specimen

8110 - 6/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03887

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Essex
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death Sudden
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Del. County Santiago
City or town Santiago
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Peter Comynoudjian 3. (b) Social Security Number ED7

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 8/21/02 6. (c) If alive, give age years

8. AGE: Years 44 Months 45 Days It less than one day hrs. min.

9. Birthplace Southport, England
(Town, county, and state)

10. Usual occupation Importer

11. Industry or business

12. Name Ohan Comynoudjian

13. Birthplace Maria Bakirgian

14. Maiden name Yurksey

15. Birthplace E.M. Sahagian

16. Informant 152 W. 42nd St N.Y.

17. Removal (Burial, cremation, or removal, Which?) Removal Date thereof 6-6-47
(month) (day) (year)

Cemetery or crematory Frank E. Campbell, Inc.

Location Madison Ave. & 81st. St., N.Y.C.

18. Funeral director Lee C. Patterson & Son

Address Quarryville, Md

19. Date rec'd by registrar June 6, 47 Registrar James E. Daugherty

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47, at 6:42 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19

and that I last saw him alive on 19

Immediate cause of death Mutilated

Due to Body

Due to Acroplane accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30-47

Where did injury occur? Port Deposit, Cecil Co. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Calver

Means of injury Injured at work?

Medical Examiner W.D. O'Donoghue

23. SIGNATURE James E. Daugherty Cecil County

Address Quarryville, Md M. D. or other

Date signed 6-1-47

7

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JUN 9 1947
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03888

1. PLACE OF DEATH:

County... Cecil
 City or town... Perry Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Cecil
 City or town... Perryville.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Bernhardt Dawson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Pearl Blansfield Dawson

7. Birth date of

deceased (mo., day, yr.)

January 3, 1910

6. (c) If alive, give age 34 years

8. AGE:

Years

Months

Days

If less than one day

37

4

13

hrs.

min.

9. Birthplace

Perryville, Cecil Co., Md.

(Town, county, and state)

10. Usual occupation

Engineer, Work Equipment

11. Industry or business

Penna. Rail Road

FATHER
MOTHER

12. Name

John B. Dawson

13. Birthplace

Md.

14. Maiden name

Mary Little

15. Birthplace

Cecil Co., Md.

16. Informant

Mary L. Dawson

Address

Perryville, Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

May 20, 1947

(month) (day) (year)

Cemetery or crematory

Principio

Location

Principio Furnace, Md.

18. Funeral director

L. A. Patterson & Son

Address

Perryville, Md.

19.

(Date rec'd by registrar)

19

May 20 47 Irene E. Daugherty
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 17 1947 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....
 and that I last saw h..... alive on..... 19.....

Immediate cause of death

Fractured
 Skull &
 Crushed Right
 side of chest

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (Mark X)

Means of injury

Injured at work?

Medical Examiner

23. SIGNATURE

R. L. Dodson M.D.
 Cecil County
 M. D. or other
 Address: Perryville, Md. Date signed: 5/17-47

THE BUREAU OF LANDS

DEPT. OF AGRICULTURE

WASHINGTON, D. C.

1947

May 17 1947

Received
of the
Bureau of Lands
for the
Department of Agriculture

RECEIVED
MAY 21 1947
BUREAU OF LANDS

Received
of the
Bureau of Lands
for the
Department of Agriculture
May 17 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03889

1. PLACE OF DEATH:

County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Cecil
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Annie Cameron Deekman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Henry Deekman
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) 10-22-1873

8. AGE: Years 73 Months 6 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace North East, Bricks Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business _____

FATHER 12. Name Robert Cameron
13. Birthplace md

MOTHER 14. Maiden name Annie Pearson
15. Birthplace md

16. Informant Arthur Cameron
Address Elkton Md

17. Buried Date thereof May 21-1947
(Burial, cremation, or removal, which?) (month, day) (year)

Cemetery or crematory Angel Hill
Location Near Elberton Md

18. Funeral director Joseph R. Frank
Address North East Md

19. May 19 1947 Registrar Elkton
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 May 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 April 1947 to 18 May 1947 and that I last saw her alive on 17 May 1947

Immediate cause of death Cerebral vascular accident DURATION _____

Due to hypertensive cardiac vascular disease

Due to arteriosclerosis due to age + diabetes

Other conditions Hemiplegia right

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George J. Klein, Jr M.D.

Address Elkton Date signed 18 May 47

MARGIN RESERVED FOR BINDING

VS A15-9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 21 1947
BUREAU 68

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changes
shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03890

96

Reg. No. G 113 NOV 4 - 1947 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Josephine De La Puente

3. (b) Social Security Number

4. Sex

F.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

MIGUEL DE LA FUENTE ASTABURUAGA

7. Birth date of

deceased (mo., day, yr.)

4/21/89

8. AGE:

Years

Months

Days

If less than one day

58

5

1

4

hrs.

min.

9. Birthplace

Chile, Chilean

(Town, county, and state)

10. Usual occupation

H.-Work.

11. Industry or business

JOSE MARZA

FATHER

12. Name

Rafael Argandoña

13. Birthplace

La Serena Chile

MOTHER

14. Maiden name

Josephine De La Puente

15. Birthplace

Valparaiso Chile

16. Informant

Mrs. Ricardo Searle

Address

Santiago Chile

17. Removal

Removal

(Burial, cremation, or removal. Which?)

Date thereof

6-6-47

Cemetery or crematory

Frank E. Campbell Inc

Location

Madison Ave at 81st St. N. Y. C.

18. Funeral director

L. C. Patterson

Address

Gwynnville, Md.

19. Date rec'd by registrar

June 6, 1947

June E. Doughty

Registrar

23. SIGNATURE

Cecil Dodson

M. D. Registrar

Address

Gwynnville, Md.

Date signed

6/30-47

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

19

at 648

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19

to

19

and that I last saw him..... alive on

19

Immediate cause of death

Myocardial infarction

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner

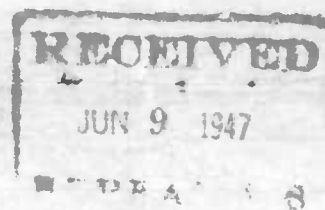
Cecil County

M. D. Registrar

Date signed

6/30-47

5



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County King
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death in home
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County King
 City or town Seattle
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 623 N. Mercer Place
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lillian Margaret Mills Delyea

3. (b) Social Security Number

207

4. Sex H 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Peter T. Delyea

7. Birth date of deceased (mo., day, yr.) unknown 6. (c) If alive, give age _____ years

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Torrone Utah
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Harry Brown13. Birthplace Utah14. Maiden name Pearl Adele Brown15. Birthplace Utah16. Informant Mr. MillsAddress 623 N. Mercer Pl.Removal Seattle Wash.17. (Burial, cremation, or removal. Which?) Date thereof 6-6-47Cemetery or crematory Greenlake Funeral HomeLocation 7217 Woodlawn Ave., Seattle, Wash.18. Funeral director Lee C. Patterson, Inc.Address Perryville, Md.19. June 16, 1947 Irene E. Daugherty

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 6:42 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Due to MutilatedDue to BodyDue to airplane crash

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-30-47Where did injury occur? Port Deposit, Md. (City or town) _____ (County) _____ (State) _____Injured at home, farm, industry, public place (where) Public CarMeans of injury Airplane Injured at work?23. SIGNATURE Allen Dodson Medical ExaminerAddress Perryville, Md. (City or town) _____ (County) _____ (State) _____Date signed 6-4-47

28

RECEIVED

JUN 9 1947

BUREAU 66

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03892

Reg. Dist. No. 96

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removed

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 47, at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

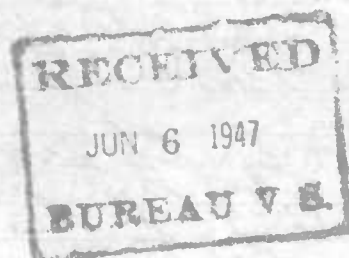
Address

Date signed

Medical Examiner

M. D. or other

Q.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: *Cecil*
 County.....
 City or town *Elkton R D 5 md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *9 days*
 Hospital, institution, or street address where death occurred:
Union Hospital
 How long in hospital or institution? *9 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Cecil*
 City or town *Elkton R D 5*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Dolas Eastridge*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *single*
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) *June 22 1934* 8. (c) If alive, give age..... years
 8. AGE: Years *12* Months *11* Days *9* If less than one day..... hrs. min.

9. Birthplace *Hemelock N C*
 (Town, county, and state)

10. Usual occupation *at school*

11. Industry or business

12. Name *E D Eastridge*

13. Birthplace *Hemelock N C*

14. Maiden name *Mary Ann Campbell*

15. Birthplace *Heaton N C*

16. Informant *A D Eastridge*

Address *Elkton md R D 5*

17. *removal* Date thereof *May 21 1947*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *West Jefferson*

Location *North Carolina*

18. Funeral director *H. W. Tiffin*

Address *Elkton, md*

19. *May 21 1947* *J R Frazer*
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *21 May 1947* at *9:20 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *12 May 1947* to *21 May 1947*
 and that I last saw her alive on *20 May 1947*

Immediate cause of death *Meningitis, diffuse* DURATION *10 days*

Due to *Mastoiditis chronic, recurrent, left.* *6 yrs.*

Due to *Otitis Media, chronic recurrent left.* *6 yrs.*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Klaus H. Kuehner M.D.* M. D. or other

Address *North East, Md* Date signed *21 May 47*

RECEIVED
MAY 23 1947
D. H. A. C. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **CECIL**
 City or town..... **U.S.N.T.C. BAINBRIDGE, MARYLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **Worked there 1 1/2 hrs**
 Hospital, institution, or street address where death occurred:
of the day of death.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **MARYLAND** County..... **CECIL**
 City or town..... **PRINCIPIO FURNACE**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

LEON CAMPBELL EDDINGTON

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife..... **RAY IRA EDDINGTON**6. (c) If alive, give age..... **47** years

7. Birth date of

deceased (mo., day, yr.) **December 11, 1895**

8. AGE:

Years

Months

Days

If less than one day

48**5****12**

.....hrs.

.....min.

9. Birthplace.....

PHILADELPHIA, PENNA.

(Town, county, and state)

10. Usual occupation.....

RIGGER - CIVIL SERVICE

11. Industry or business

FATHER 12. Name **DONALD C. EDDINGTON**13. Birthplace **SCOTLAND**MOTHER 14. Maiden name **Sarah Cory**15. Birthplace **England**

16. Informant.....

VERNON A. EDDINGTON

(son)

Address

CHARLESTOWN, MARYLAND17. **Burial**

(Burial, cremation, or removal, Which?)

Date thereof..... **May 26-1947**

(month)(day)(year)

Cemetery or crematory.....

Methodist

Location.....

Principio Maryland

18. Funeral director.....

Joseph R. Shaw

Address

North East, Md19. **May 24**
(Date rec'd by registrar)

19. 47

Irene E. Laughlin

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **23 May**..... 19 **47**..... at..... **9 A.**..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him..... alive on.....19.....

Immediate cause of death.....

ELECTRIC SHOCK

DURATION

Due to..... **CONTACT.**

Due to.....

Other conditions

Boom hit high tension wire + Eddington**had hand on crane [6/25/47 also]**
(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of..... **5/23/47**

Where did injury occur?.....

Bainbridge
(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

(see above)

Injured at work?.....

yes

23. SIGNATURE.....

Address.....

Medical Examiner

for Cecil County

M. D. or other

Date signed..... **5/29/47**

MARGIN RESERVED FOR BINDING

VS 415

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(now)

RECEIVED
MAY 27 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil

City or town... Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos

Hospital, institution, or street address where death occurred:
Elkton RFD 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Cecil

City or town... Rural
(If outside city or town limits, write RURAL and give nearest town)Street No... Elkton R.D. 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Thomas Edmondson

3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Sept 26 - 1866

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80

7

12

hrs.

min.

9. Birthplace

Md
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

William Edmondson

13. Birthplace

Md

MOTHER

14. Maiden name

Mrs Edmondson

15. Birthplace

Md

16. Informant

Mrs William Spry

Address

Elkton R.D. 3

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 10 1947
(month) (day) (year)

Cemetery or crematory

White Clay Creek

Location

Newman Del R.D.

18. Funeral director

R. J. Jones

Address

Newman Del

19.

May 9 1947
(Date rec'd by registrar)J. H. Frazer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 8

19 47 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 30 19 47 to May 8 19 47

and that I last saw him alive on May 8 19 47

Immediate cause of death

Uremia

Due to

Acute nephritis

Due to

Intestinal obstruction

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James Johnson M.D.

M. D. or other

Address

Elkton, Md

Date signed 5/9/47

03895

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RECEIVED STATE DEPARTMENT OF HEALTH

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RECEIVED
MAY 10 1947
BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03896

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH

County ReeCity or town Earlville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ree County New CastleCity or town Millington
(If outside city or town limits, write RURAL and give nearest town)Street No. 404 Fifth St
(If rural, give LOCATION)2.(a) If veteran, name war ☒

3. (a) FULL NAME

George Fields

3. (b) Social Security Number

4. Sex M5. Color or race col.6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1872

6. (c) If alive, give age _____ years

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer work

11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Mrs. George K. BaileyAddress Earlville Md.17. Burial June 4, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Acilton ColoredLocation Acilton Md.18. Funeral director Edward H. BrownAddress Millington Md.19. June 4, 1947 Mrs. Hester W. Cheyney

(Date rec'd by registrar) Registrar's Address

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 47, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____,

and that I last saw him _____ alive on _____ 19_____,

Immediate cause of death Senile pneumonia

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Dodson Medical ExaminerRee County

M. D. or other _____

Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03897

1. PLACE OF DEATH:

County Cecil

City or town Elk Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Cecil County

City or town Elk Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Junior Lee Horrester

3. (b) Social Security Number

212-26-4164

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 1928

8. AGE: Years 18 Months 4 Days 16 If less than one day hrs. min.

8. Birthplace Warrensville N.C.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Paper mill

12. Name Odell Horrester

13. Birthplace Johnson Co Tenn

14. Maiden name Virginia E Horrester

15. Birthplace Watauga Co N.C.

16. Informant Mrs. Odell Horrester

Address Elk Mills

17. Burial, cremation, or removal, Which? Burial Date thereof May 12, 1947

(month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md

18. Funeral director H. W. Pippin

Address Elkton, Md

19. May 12 1947 F. H. Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 10... 19...

and that I last saw h... alive on 19...

Immediate cause of death Perforated neck

DURATION

Due to Crushed right side of chest

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-10-47

Where did injury occur? Elk Mills Cecil Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where) Highway

Means of injury Automobile Injured at work?

23. SIGNATURE R. L. Jackson M.D. Medical Examiner

for Cecil County

M. D. or other

Address Rising Sun Md Date signed 5/10-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 17 1947

BUREAU 66

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03898

96

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....*Baltimore*
 City or town.....*West Desert Rural*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death.....*11 days*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jules E. Gans

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Dorothy E. Gans

7. Birth date of deceased (mo., day, yr.)

12-11-1911

8. AGE:

Years

36

Months

Days

If less than one day

hrs.

min.

9. Birthplace

New York City
(Town, county, and state)

10. Usual occupation

Electrician

11. Industry or business

12. Name

Leubron

13. Birthplace

14. Maiden name

Leubron

15. Birthplace

Imm. H. B. Over

16. Informant

1800 Ave W Brooklyn

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

6-4-47

(month) (day) (year)

Cemetery or crematory

Flatbush Memorial Chapel

Location

1283 Coney Island Ave., Brooklyn, N.Y.

18. Funeral director

Leubron & Son

Address

Brooklyn, Md

19. June 4, 1947

(Date rec'd by registrar)

James E. Dougherty

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*N.Y.* County.....*Kings*
 City or town.....*Brooklyn*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*1900 Ave. W.*
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30, 1947, at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Myocardial infarction

Due to

Coronary artery disease

Due to

Arteriosclerosis

Other conditions

Arteriosclerosis

Major findings of operations

.....Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....*6-30-47*Where did injury occur.....(City or town).....(County).....(State).....*Brooklyn*Injured at home, farm, industry, public place (where?).....*Public Place*Means of injury.....*Arteriosclerosis*.....Injured at work?

23. SIGNATURE

James E. Dougherty

Address

Medical Examiner

*James E. Dougherty*M. D. or other.....*6-30-47*

13

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 6 1947

BUREAU V.B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

Removal

Date thereof

6-6-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

P. M. Williams & Son

Location

St. Thomas, Ontario, Canada

18. Funeral director

Address

19.

Date rec'd by registrar

19. 47

June E. Laugherty

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 19. 47

at

6:42 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw him..... alive on

19.....

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medical Examiner

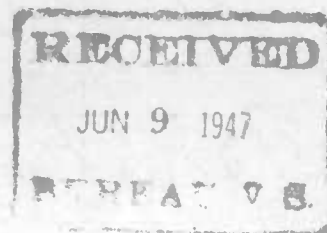
County

M. D. or other

Address

Date signed

5-2.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03909

1. PLACE OF DEATH:

County Leggit
 City or town Rockton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? hours
 Hospital, institution, or street address where death occurred:
Union Hosp.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Del. County Newcastle
 City or town Pear
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph L. Goff Sr.

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 32 1882

8. AGE: Years 65 Months — Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Christiana Del
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business _____

12. Name Joseph L. Goff Sr.

13. Birthplace New Jersey

14. Maiden name M. Reed

15. Birthplace M. Reed

16. Informant Charles A. Goff

Address 605 W. 5th St. Newark Del

17. Burial, cremation, or removal. Which? Burial Date thereof May 28 47
 (month) (day) (year)

Cemetery or crematory Isle of Del

Location near Newark Del

18. Funeral director P. J. Jones

Address Newark Del

19. May 27 19 47 J. R. Frazer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 47 at 8:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Acute Coronary Thrombosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Alfredson M. Medical Examiner

Address Cecil County

Date signed 5/24-47

RECEIVED

MAY 30 1947

BUREAU VS

205574

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

03901

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town North East
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war not a veteran

3. (a) FULL NAME

William Charles Graw

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

B. (b) Name of husband or wife

Matthe H Graw

7. Birth date of deceased (mo., day, yr.)

December 27 1865

6. (c) If alive, give age 76 years

8. AGE:

Years

Months

Days

If less than one day

81

4

18

hrs.

min.

9. Birthplace

North East Cecil Md
(Town, county, and state)

10. Usual occupation

Basket maker

11. Industry or business

MOTHER FATHER

12. Name

Charles Graw

13. Birthplace

Md

14. Maiden name

Adams

15. Birthplace

Perry

16. Informant

Matthe H Graw

Address

North East Md

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

May 19 47
(month) (day) (year)

Cemetery or crematory

Methodist

Location

North East Md

18. Funeral director

Joseph A Graw

Address

North East Md

19. May 18 19 47
(Date rec'd by registrar)

J R Graw

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 May 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 May 19 47 to 15 May 19 47

and that I last saw him alive on 15 May 19 47

Immediate cause of death

Cerebral Thrombosis

DURATION

6 hrs

Due to

Generalized Arteriosclerosis

5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Klaus H Hubner M.D.

M. D. or other

Address North East Md Date signed 16 May 47

MARGIN RESERVED FOR (B)INDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 21 1947

BUREAU 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County Cecil
 City or town North East Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Cecil
 City or town North East Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war not a veteran

3. (a) FULL NAME

Raymond C. Greenwood

3. (b) Social Security Number

219-18-5080

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct 20 1894
 6. (c) If alive, give age _____ years

8. AGE: Years 51 Months 7 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Seneca Falls, Seneca Co. N.Y.
 (Town, county, and state)

10. Usual occupation Mechanical Engineer

11. Industry or business

12. Name Larry S. Greenwood13. Birthplace Martin, New York14. Maiden name Catharine A. Crossman15. Birthplace Coroga, New York16. Informant E. L. GreenwoodAddress North East Md17. Removal Date thereof May 31 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CorogaLocation Coroga, Seneca Co. N.Y.18. Funeral director Joseph R. GrantAddress North East Md19. 5/30 19 46 L. D. & C. Lewis
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 46 at 7 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 19 46 to May 27 19 46and that I last saw him alive on May 27 19 46Immediate cause of death Coronary ThrombosisDURATION 2 hr

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE D. Green Cumbeull 1946
May 24 1946 M. D. or otherAddress North East Md Date signed May 24 1946

10720

RECEIVED POSTAL SERVICE

U.S. DEPARTMENT OF JUSTICE

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JUN 2 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03902

96

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Port Deposit Rural
 City or town Sudden Landwing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rafael A. Grillo MD.

3. (b) Social Security Number

ED7

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Carmen R. D. Grillo

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age 38 years

8. AGE:

Years

Months

Days

If less than one day

52

hrs.

min.

9. Birthplace

Costa Rica
(Town, county, and state)

10. Usual occupation

Medical Doctor

11. Industry or business

FATHER

12. Name

Manuel Grillo

13. Birthplace

Costa Rica

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

Joaquin M. Gutierrez
219 N. 80th St.

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-7-47
(month) (day) (year)

Cemetery or crematory

Location

San Jose, Costa Rica

18. Funeral director

Address

Lee C. Patterson & Son
Perryville, Md

19.

(Date rec'd by registrar)

19 47June 7

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Costa Rica, Cent Amer.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name War

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3019 47at 6420

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Myocardial

Due to

Ischemic

Due to

Arteriosclerotic

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

5-30-47

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Propane

Injured at work?

Medical Examiner

for Cecil County

M. D. or other

23. SIGNATURE

William S. ...

Date signed

6-3-47

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

[Handwritten signature]

31

RECEIVED
JUN 11 1947
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 039035

1. PLACE OF DEATH.

County Cecil
 City or town Conowingo, rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7.5 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cecil
 City or town Conowingo, rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Florence K. Hill

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife William Hill
 7. Birth date of deceased (mo., day, yr.) Aug. 12, 1971 8. (c) If alive, give age 7.6 years
 8. AGE: Years 75 Months 9 Days 15 hrs. min.

9. Birthplace Conowingo, md.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business

12. Name Stephen Hanna
 13. Birthplace Cecil Co. md.
 14. Maiden name Elizabeth Johnson
 15. Birthplace Penna.

16. Informant Mr. William Hill
 Address Conowingo, md. R. H. D.

17. Burial Date thereof May 31, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory West Nottingham
 Location Near Colora, md.

18. Funeral director J. E. Tyson
 Address Rising Sun, md.

19. May 29-47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... to 19...
 and that I last saw him alive on 19...

Immediate cause of death Acute coronary thrombosis
 Due to...
 Due to...
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE P. L. Dodson Medical Examiner
Rising Sun, md. Cecil County
 M. D. or other
 Address... Date signed 5/28-47

RECEIVED

MAY 31 1947

BUREAU V. S.

46

RECEIVED
JUN 6 1947
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 03905

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 years
 Hospital, institution, or street address where death occurred:
 Union Hosp.
 How long in hospital or institution?..... 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland Cecil
 City or town..... Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Frank L Hudson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

?

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 25, 1888

8. AGE:

Years

Months

Days

If less than one day

58

hrs.

min.

9. Birthplace

New Albany Ind

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

MOTHER FATHER

12. Name

David L Hudson

13. Birthplace

New Albany Ind

14. Maiden name

no information

15. Birthplace

no information

16. Informant

Sophia E Steele

Address

Elkton Ind

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof..... May 22, 1947
(month) (day) (year)

Cemetery or crematory

Elkton Cemetery

Location

Elkton Maryland

18. Funeral director

H. W. Rippie

Address

Elkton Maryland

19. May 21, 1947

(Date received by registrar)

19 47

J. R. Frazier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 20..... 1947..... at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15..... 1947..... to May 20..... 1947

and that I last saw him alive on May 20..... 1947

Immediate cause of death.....

Lupus erythematosus

DURATION

972

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

J. R. Frazier

M. D. or other

Address..... Elkton Ind Date signed..... May 22, 1947

RECEIVED

MAY 23 1947

51 RFA 8

Evidence for the changes of age + June 38 is shown on

Evidence for the changes made shown on

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 110 JUN 9 1947 CERTIFICATE OF DEATH

 77c
 6 110 6/1 43
 Reg. Dist. No.

1. PLACE OF DEATH:

 County... Cecil
 City or town... Elcton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 1/2 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Alfred Izatt

3. (b) Social Security Number

001-01-5124
1009-11-1E

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Div.

6. (b) Name of husband or wife Maud E Izatt

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) June 10/11/1910 14, 1908

8. AGE: Years 36 Months 11 Days 17 hrs. min.

9. Birthplace... New Scotland, Gorham, Me.

10. Usual occupation... Machinist

11. Industry or business

12. Name... Alexander R Izatt

13. Birthplace... New Scotland

14. Maiden name... Fernandine

15. Birthplace... Portland, Me.

16. Informant... Dr. D. Brown

Address... Praying Bee, Md.

17. Removal... Date thereof June 3, 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory... Gorham, New Hampshire

Location... New Hampshire

18. Funeral director... H. Whipple

Address... Elcton, Md.

19. June 3, 1947 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

 (For newborn infants give residence of mother)
 State... Md. County... Cecil
 City or town... Elcton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Elcton Hall
 (If rural, give LOCATION)

2. (a) If veteran, name war

001-01-5124

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death... Acute Alveolitis

DUE TO... Acute Alveolitis

Other conditions... (Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? Elcton, Cecil, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

Medical Examiner... Cecil County

23. SIGNATURE... M. D. or other

Address... Praying Bee, Md. Date signed 6-3-47

RECEIVED

JUN 6 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

03906

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

66

..... hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

FATHER

12. Name.....

John Johnson

13. Birthplace.....

Maryland

MOTHER

14. Maiden name.....

Elizabeth Riley

15. Birthplace.....

Maryland

16. Informant.....

Otis Harris

Address.....

Cecilton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

May 20 1947

(month) (day) (year)

Cemetery or crematory.....

Cecilton

Location.....

Cecilton, Md.

18. Funeral director.....

Austin O. Gaulb.

Address.....

827 Pine St. Wilkes Del.

19. May 19 1947

(Date rec'd by registrar)

H. F. Frazier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 16 47 920P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... alive on.....

Immediate cause of death.....

DURATION

Due to.....

Doe to.....

Other conditions.....

old left inguinal

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address.....

Medical Examiner

M. D. or other

for Cecil County

Date signed.....

CERTIFICATE OF DEATH

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RECEIVED
MAY 21 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03907

94

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

Female

white

Married

8. (b) Name of husband or wife.....

Filmore H Jones

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

October 8 1864

8. AGE:

Years

Months

Days

If less than one day

82

7

4

..... hrs.

..... min.

9. Birthplace.....

Piney Run Cecil Co Md

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

FATHER

12. Name.....

George W Chidester

13. Birthplace.....

Md

MOTHER

14. Maiden name.....

Mary C Preston

15. Birthplace.....

Md

16. Informant.....

Filmore H Jones

Address.....

North East, Md

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

May 15 1947

(month) (day) (year)

Cemetery or crematory.....

Union

Location.....

Elbston Rural, Md

18. Funeral director.....

Joseph R Grant

Address.....

North East, Md

19.

(Date rec'd by registrar)

1947

Lida & Owens

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

12 May

19..47

at

1 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August

19..46

to

12 May

19..47

and that I last saw him

alive on

11 May

19..47

Immediate cause of death.....

Pulmonary Edema

DURATION

1 day

Due to.....

Hypertensive Cardiovascular Disease

15 years

Due to.....

Other conditions.....

-

(Include pregnancy within 3 months of death)

Major findings of operations.....

-

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Klaus H Huebner

M.D.

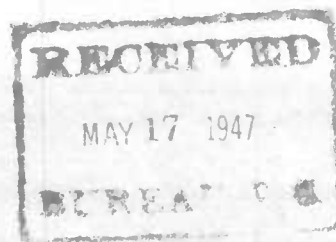
M. D. or other

Address.....

North East, Md

Date signed

12 May 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173

03910

Reg. Dist. No. 96

1. PLACE OF DEATH:

County St. Louis
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Hidden Landing
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Hudson
 City or town Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 416-74 St North Bay View
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Benjamin Katz

3. (b) Social Security Number

EDY4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Little Katz7. Birth date of deceased (mo., day, y.) Feb. 27 1897 6. (c) If alive, give age _____ years8. AGE: Years 50 Months 3 Days 8 If less than one day _____ hrs. _____ min.9. Birthplace N. Y. (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Chas. Meister13. Birthplace Austria14. Maiden name Anna Rosenthal15. Birthplace Russia16. Informant Mr. KatzAddress 416-74 St North Bay View17. Removal Removal Date thereof 6-6-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory West End Funeral ChapelLocation Amsterdam Ave. & 91st St., N.Y.C.18. Funeral director See C. Patterson & SonAddress Gerryville, Md19. June 16 19 47 June E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47, at 642 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION

Due to MutilatedDue to BodyDue to Airplane head

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

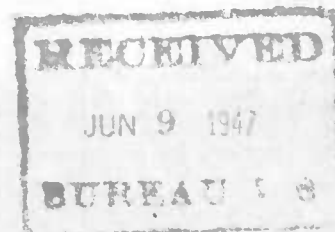
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-30-47Where did injury occur? Port Deposit Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public CarrierMeans of injury Airplane Injured at work?Medical Examiner Bl. Dockson MD23. SIGNATURE Bl. Dockson MD for Cecil County

M. D. or other

Address Bl. Dockson MD Date signed 6-4-47

19



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03908

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Prince Georges
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Sweden Lanning
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lillie Katz

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Benjamin Katz7. Birth date of deceased (mo., day, year) Feb. 27 1897

8. AGE: Years 50 Months 3 Days 3 B. (c) If alive, give age _____ years
 If less than one day _____ hrs. _____ min.

9. Birthplace New York City
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Isabel Katz13. Birthplace Russia14. Maiden name Lillie Weisler15. Birthplace N.Y.16. Informant Mr. KatzAddress 416 - 74 St. Northbury N.Y.

17. Removal Removal Date thereof 6-6-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West End Funeral ChapelLocation Amsterdam Ave. & 91st St., N.Y.C.18. Funeral director Lee C. Patterson & SonAddress Perryville, Md.

19. June 6 19. 47 Irma E. Dougherty
 (Date rec'd by registrar) (Year) (Signature)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State N.Y. County Hudson
 City or town North Bergen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 416 - 74 St. Northbury N.Y.
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19. 47 6 430 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19. _____ to _____ 19. _____

and that I last saw him _____ alive on _____ 19. _____

Immediate cause of death

Inflamed
body.
airplane.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30-47Where did injury occur? Port Deposit Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public CorridorMeans of injury Airplane Injured at work?Medical Examiner Will Doonan Cecil County23. SIGNATURE Will Doonan M. D. or otherAddress Prising Sun Md Date signed 6-6-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

42

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03911

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County St. Louis
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State Conn. County Bridgeport
City or town Bridgeport
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Bertie Wilman

3. (b) Social Security Number

ED

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Joseph Wilman

6. (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) Aug 14 1895

8. AGE: Years 51 Months 9 Days 16 If less than one day hrs. min.

9. Birthplace Haverstraw N.Y.
(Town, county, and state)

10. Usual occupation Store Manager

11. Industry or business

12. Name Mrs. Provitch

13. Birthplace Russia

14. Maiden name Savara

15. Birthplace Russia

16. Informant M. M. Smith

Address 863 Westbury Avenue

17. Removal (Burial, cremation, or removal. Which?) Removal Date thereof 6-3-47
(month) (day) (year)

Location Riverside Chapel Sons of Jacob, New York City, N.Y.

18. Funeral director L. A. Patterson & Son

Address Perryville, Md.

19. June 3 19 47 James E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 19 47 6420

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on 19

Immediate cause of death Intoxication of body

Due to Airplane Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident Date of 6/30-47
Accident, suicide, or homicide Port Deposit Cecil Md
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Carrier

Means of injury Airplane Injured at work?

Medical Examiner Cecil County

23. SIGNATURE M. D. or other

Address Date signed 6/31-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

25

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03912

173

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
City or town Port Deposit, Rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sudden Landing
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Dela. County Wode.
City or town Newark
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2125 S.W. 23 Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louis Reed. King

3. (b) Social Security Number

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Sept 11 1894

8. AGE: Years 52 Months 7 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Hartles, Ken.
(Town, county, and state)

10. Usual occupation attorney

11. Industry or business

12. Name John H. King

13. Birthplace Mary King

14. Maiden name

15. Birthplace Min. Parham.

16. Informant Dr. C. C. C.

Address Removal Date thereof 6-6-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philbrick Funeral Home

Location 660 W. Flagler St., Miami, Fla.

18. Funeral director L. A. Patterson & Son

Address Perryville, Md.

19. June 6 19 47 June E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47 at 6:42 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____
and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Mutilated

Due to body

Due to airplane

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30-47

Where did injury occur Port Deposit, Del. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Carriage

Means of injury Airplane Injured at work?

23. SIGNATURE R. L. Doxlain Medical Examiner

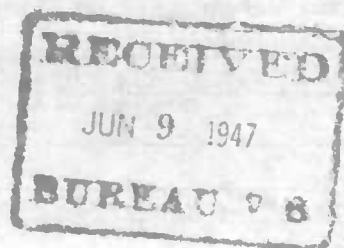
Address Perryville, Md. Date signed 6-3-47
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

32.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

CERTIFICATE OF DEATH

Reg. Dist. No. 05913 96

1. PLACE OF DEATH:

County Putnam Rural
 City or town Putnam Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 10 days
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State N.J. County Hudson
 City or town Union City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1507 Fernside Dr
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Mary Klarmann

3. (b) Social Security Number

E04

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Harold Klarmann

7. Birth date of

deceased (mo., day, yr.)

Aug 5 - 1907

8. (c) If alive, give age

38 years

8. AGE:

Years 39 Months 9 Days 25
 If less than one day _____ hrs. _____ min.

9. Birthplace

Jersey City, N.J.

10. Usual occupation

Housewife

11. Industry or business

Andrew J. Lyons

FATHER

12. Name

Bellville, N.J.

13. Birthplace

Florence J. Harris

14. Maiden name

Jersey City, N.J.

15. Birthplace

Harold Klarmann

16. Informant

Miami, Fla.

Address

Removal

Date thereof 6-4-47

(Burial, cremation, or removal. Which?)

Combs Funeral Home

1539 N.E. 2nd Ave., Miami, Florida

Location

Lee A. Patterson & Son

18. Funeral director

Bellville, Md.

Address

June 4, 47

Date rec'd by registrar

19. June 4, 47

Dr. E. Dougherty

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19_____, _____ 19_____, _____ 19_____

and that I last saw him _____ alive on _____ 19_____

Immediate cause of death

Mutilated

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City) _____ (town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Medical Examiner _____

M. D. or other _____

Address _____ Date signed _____

23. SIGNATURE _____

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

87

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JUN 6 1947
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Fort Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Sudden Landing
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Conn.
 County
 City or town Stamford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 13 S. Chittenden Road.
 (If rural, give LOCATION)
 2(a) If veteran, name war world war I, U. S. Navy

3. (a) FULL NAME

Abraham Kahn

3. (b) Social Security Number

E107

4. Sex male
 5. Color or race white
 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1901

8. AGE: Years 45- Months 9 Days 25 If less than one day hrs. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual occupation Income tax & auditor

11. Industry or business

12. Name Jacob Kahn

13. Birthplace Russia

14. Maiden name Ida Big

15. Birthplace Russia

16. Informant Records - Med Exem

Address of Cecil Co., Md

17. Removal Date thereof 6-4-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Leo P. Gallagher Fun Home

Location 20 Suburban Ave., Stamford, Conn.

18. Funeral director S. C. Patterson & Son

Address Perryville, Md

19. Date rec'd by Registrar June 4, 47 James E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death DURATION

Disseminated

Due to body

Due to Aeroplane Accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 5/30-47

Where did injury occur Fort Deposit, Conn. (City or town) (County) (State)

Injured at home, farm, industry, public place, elsewhere Public Carrier

Means of transport Aeroplane Injured at work?

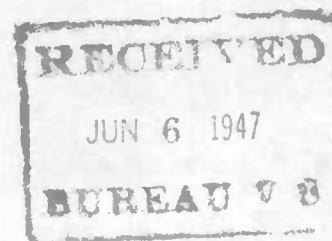
Medical Examiner

S. C. Patterson M.D. Cecil County

23. SIGNATURE M. D. or other

Address Young Sun Md Date signed 6/8-47

44



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:

County Stafford
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Sudden
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Conn. County Stafford
 City or town Stafford Conn.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 132 Culloden Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Samuel M. Kohn

3. (b) Social Security Number

807

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1933

8. AGE: Years Months Days It less than one day

13 8 29 hrs. min.

9. Birthplace Stafford, Conn.10. Usual occupation Student

11. Industry or business

12. Name Abraham Kohn13. Birthplace Russia14. Maiden name Mary Robinson15. Birthplace Stafford, Conn.16. Informant Records, Med ExaminerAddress of Cecil Co. Md17. Removal Date thereof 6-4-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Leo P. Gallagher Fun. HomeLocation 20 Suburban Ave., Stafford, Conn.18. Funeral director Lee E. Patterson & SonAddress Pawcatuck, Md19. June 4, 1947 Irma E. Dougherty

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Due to Mutilated bodyDue to Aviation Accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 5/30-47Where did injury occur Stafford Conn. (City or town) (County) (State)

Injured at home, farm, industry, public place, or other

Means of injury Aviation Injured at work?

Medical Examiner

Signature Dr. Douglas Cecil County

M. D. or other

Address Waring Sun Hill Date signed 6-2-47

8

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JUN 6 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03915

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 47

June T. Dougherty

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

19

47, at 642 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Amputation of body

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner

for Cecil County

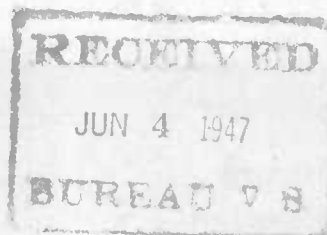
23. SIGNATURE

M. D. or other

Address

Date signed

49



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03916

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Essex
 City or town Port Republic Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Sudden Landing
 Hospital, institution, or street address where death occurred:

How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.Y. County Bro. Manhattan
 City or town 2650 Broadway N.Y.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Jack J. London

3.(b) Social Security Number

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Bella London

7. Birth date of deceased (mo., day, yr.) Feb. 15 1901
 6.(c) If alive, give age _____ years

8. AGE: Years 46 Months 3 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Elmhurst Ont. Eng.
 (Town, county, and state)

10. Usual occupation Rail Estate

11. Industry or business _____

12. Name Morris London13. Birthplace Russia14. Maiden name Isabell Guisburg15. Birthplace Russia16. Informant Leslie LondonAddress Roscoe N.Y.17. Removal June 3 1947

(Burial, cremation, or removal. Which?) _____ (month) (day) (year)

Cemetery or crematory Riverside Mem. ChapelLocation 76th & Amsterdam Ave N.Y. N.Y.18. Funeral director W. C. Callahan & SonAddress Perryville, Md19. June 3 1947 Dr. E. Dugan
 (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

Ed 7.

20. DATE OF DEATH May 80 1947 at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Incapacitated
Today
 Due to _____
 Due to airplane accident
 Other conditions _____

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur Port Republic, Md (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury airplane Injured at work? _____

23. SIGNATURE R. L. Doolittle Medical Examiner
Pracey Dugan _____ County _____
 Address _____ Date signed 5/8-47

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

RECEIVED
JUN 4 1947
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03917

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

Zacary T. Loveless

3. (b) Social Security Number

4. Sex M. 5. Color or race Wh 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4, 1887

8. AGE: Years 60. Months 4. Days 2. If less than one day hrs. min.

9. Birthplace Chesapeake City
(Town, county, and state)

10. Usual occupation U.S. Gov. Post Inspector

11. Industry or business

12. Name John R. Loveless

13. Birthplace New Jersey

14. Maiden name Ida Mae Loveless

15. Birthplace Pa

16. Informant Mrs Mary Loveless

Address Chesapeake City, Md

17. Burial Date hereof May 8/47

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Bethel

Location near Chesapeake City, Md

18. Funeral director H. W. H. H.

Address Elkton, Md

19. May 8, 1947 J. H. Frazer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1947, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1947, to May 6, 1947,

and that I last saw him alive on May 5, 1947.

Immediate cause of death Coronary Thrombosis

DURATION April 16 -

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Fred R. Sprecker, M.D.

Address Elkton, Md M. D. or other

Date signed May 7, 1947

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAY 10 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

I. PLACE OF DEATH:

County Blair
 City or town Brookport Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Sudden
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State NEW YORK County NEW YORK
 City or town Elmont, Long Island
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 82 Randall Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Theodore Lundstrom

3. (b) Social Security Number

EDX

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M W. Single

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 22 - 1916

8. AGE: Years Months Days If less than one day

30 9 8 hrs. min.

9. Birthplace NEW YORK City - N.Y.
(Town, county, and state)10. Usual occupation Flight Attendant11. Industry or business Air Lines12. Name Charles Lundstrom13. Birthplace Finland14. Maiden name Ms. Brown15. Birthplace Finland16. Informant Records Eastern Air LinesAddress New York City17. Removed Date thereof 6-24-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chas. F. Krauss Fun. HomeLocation Franklin Sq. S.I. N.Y.18. Funeral director Lu A. Patterson & SonAddress Perryville, Md19. June 4, 1947 Drene E. Dougherty
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47 at 6:42 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Mutilated
Body
Airplane

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 5-30-47
Port of Spain, Md
 Where did injury occur? (City or town) (County) (State)

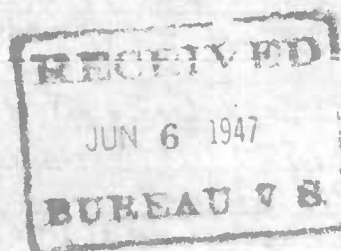
Injured at home, farm, industry, public place (where?) Public CarrierMeans of injury Airplane Injured at work?23. SIGNATURE Phl Dodson MD Medical ExaminerWilmington Md M. D. or otherAddress Wilmington Md Date signed 6-3-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03919 96

1. PLACE OF DEATH:

County Sevier
City or town Portale, rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death Several months
Hospital, institution, or street address where death occurred:
Now long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ala. County Wade.
City or town Pratt
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Leo Machtei

3. (b) Social Security Number

4. Sex M. 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 1 1901

8. AGE: Years 26 Months 4 Days 30 It less than one day
hrs. min.

9. Birthplace New York City N.Y.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name S. M. Machtei

13. Birthplace Prussia

14. Maiden name Miriam Pasternak

15. Birthplace Austria

16. Informant S. M. Machtei

Address Pratt Ala.

17. Removal Date thereof May 31 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Bolton, Md.

18. Funeral director Ben A. Hoffman & Son

Address Prattville, Md.

19. May 31 1947 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Asphyxiation of body

Due to

Due to Aeroplane accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: It death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur Pratt Ala. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Aeroplane Injured at work?

Medical Examiner

Dr. Doolson Medical Examiner

Address Prattville, Md.

23. SIGNATURE Franky S. Smith M. D. or other

Date signed 6/3-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

CONFIDENTIAL

RECEIVED
JUN 3 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03920 96

1. PLACE OF DEATH:

County Cecil
 City or town Pat. Cecil Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? See address
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pa. County DaDe
 City or town Miami
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. See address
 (If rural, give LOCATION)
 2. (a) If veteran, name war See address

3. (a) FULL NAME

Lucenie Stella Machter

3. (b) Social Security Number

807

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 14 1917 8. (c) If alive, give age See address years

8. AGE: Years 29 Months 10 Days 16 If less than one day See address hrs. See address min.

9. Birthplace Yonkers N.Y.
 (Town, county, and state)

10. Usual occupation R-N

11. Industry or business See address

12. Name B. M. Machter

13. Birthplace See address

14. Maiden name Sarah Rosey Bloom

15. Birthplace England

16. Informant B. M. Machter

Address Miami Pa.

17. Removal Date thereof May 31 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory See address

Location Baltimore Md

18. Funeral director See address

Address See address

19. May 31 1947 June E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 6:42 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from See address to See address 19 See address

and that I last saw him See address alive on See address 19 See address

Immediate cause of death Mittigation of body

Due to See address

Due to See address

Other conditions See address

(Include pregnancy within 3 months of death)

Major findings of operations See address

Date of op. See address

Autopsy results See address

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide See address Date of See address

Where did injury occur? See address (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) See address

Means of injury See address Injured at work? See address

Medical Examiner See address

23. SIGNATURE See address

Address See address

Date signed See address

MAINTAIN TO THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE OF NEW YORK

RECEIVED
JUN 3 1947
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03921

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Port Deposit Rural
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Sudden Landing
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County
 City or town 683 Mercer Place
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 683 Mercer Place
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Ruth Malan

3. (b) Social Security Number

E67

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

42

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

ProvoUtah

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

H. J. Brown

13. Birthplace

Utah

MOTHER

14. Maiden name

Pearl Alice Brown

15. Birthplace

Utah

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Removal

Date thereof

6-6-47

(month) (day) (year)

Cemetery or crematory

Greenlake Funeral Home

Location

7217 Woodlawn Ave., Seattle, Wash.

18. Funeral director

Address

Lee C. Patterson & SonGreenlake, Md.

19.

(Date rec'd by registrar)

19. 47

Dr. E. Dougherty

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

19. 47

at

6430 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 47

to

19. 47

and that I last saw h. alive on

19. 47

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Dr. E. Dougherty

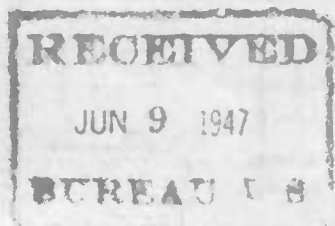
Medical Examiner

M. D. or other

Date signed

6-5-47

16



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

03922

Reg. Dist. No. 92

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Cecil

City or town... Elkton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... less than 1 day

Hospital, institution, or street address where death occurred

Main Hospital - Cecil

How long in hospital or institution? 30 days

3. (a) FULL NAME

Francis M. Marcus

4. Sex... male

5. Color or race... white

6. (a) Single, married, widowed, or divorced... Single

6. (b) Name of husband or wife

6. (c) If alive, give age... 47 years

7. Birth date of deceased (mo., day, yr.)... Nov 22 - 1887

8. AGE: Years... 59

Months... 6

Days... 14

If less than one day... hrs. min.

9. Birthplace... Elkton Md

(Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business

12. Name... Hyland Marcus

13. Birthplace... Elkton Md

14. Maiden name... Anne W Price

15. Birthplace... Cecilton. Md

16. Informant... Mrs Jacob Rothwell

Address... Elkton Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... May 23 1947

(month) (day) (year)

Cemetery or crematory... Elkton cemetery

Location... Elkton Md

18. Funeral director... W. W. Pissie

Address... Elkton. Md

19. May 21 1947

(Date rec'd by registrar)

FR Frazier

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Cecil

City or town... Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No... 1016 Sanderson Lane

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 20 - 1947 at 10:23 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 22 - 1947 to May 20 1947

and that I last saw him alive on May 19 - 1947

Immediate cause of death

DURATION

Cerebral aneurysm

Due to

Cerebral aneurysm of Basilar 1 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Cerebral aneurysm of Basilar

Date of op... 5/11/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... W. W. Pissie

M. D. or other

Address... W. W. Pissie

Date signed... May 20 1947

RECEIVED

MAY 23 1947

RECEIVED

6

RECEIVED

MAY 27 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 039246

1. PLACE OF DEATH:

County Cecil
 City or town Post Deposit Rural
 (If outside city or town limits write RURAL and give nearest town)
 How long in above place of death? Sudden standing
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)
 State Ct County Albany
 City or town Cashoes
 (If outside city or town limits write RURAL and give nearest town)
 Street No. West Columbia St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Alice Esmeralda Mayott

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 22 1893 6. (c) If alive, give age _____ years8. AGE: Years 54 Months 4 Days 8 If less than one day _____ hrs. _____ min.9. Birthplace Cashoes, N.Y. (Town, county, and state)10. Usual occupation Med. Missionary

11. Industry or business

12. Name Jacob H. Mayott13. Birthplace Grand Island, N.Y.14. Maiden name Sarah Ellis15. Birthplace Tray, N.Y.18. Informant Mabel MayottAddress West Columbia St. Cashoes, N.Y.17. Removal (Burial, cremation, or removal, Which?) Removal Date thereof 6-5-47 (month) (day) (year)Cemetery or crematory Angas Mc AfterLocation Cashoes, N.Y.18. Funeral director Lu A. Patterson & SonAddress Quincyville, Md19. June 5 19 47 Irma E. Dougherty Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47 642 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Due to MutilatedDue to BodyDue to Airplane crash

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Airplane Injured at work? _____

Medical Examiner _____

Cecil County _____

23. SIGNATURE W. D. O'Leary M. D. or other _____Address Quincyville, Md Date signed 6-4-47

50

RECEIVED

JUN 7 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03925 96

Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age. 43 years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1947

June 6

1947

June 6

1947

June 6

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June 6

1947

June 6

1947

June 6

1947

June 6

1947

June 6

1947

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30

1947

at

6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him

alive on

19

Immediate cause of death

Mutilation

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner

23. SIGNATURE

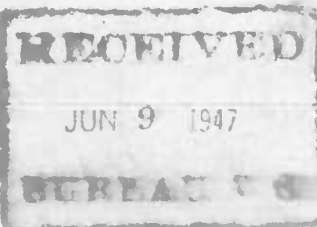
M. D. or other

Address

Date signed

6-5-47

H5



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173

03926

96

Reg. Dist. No.

1. PLACE OF DEATH:

County.....Baltimore
 City or town.....East Pratt Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death.....Sudden
 Hospital, institution, or street address where death occurred:.....Landis

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....MD County.....New Haven
 City or town.....Chesters
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Forest St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Donna Medling

3. (b) Social Security Number

4. Sex.....M 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married

6.(b) Name of husband or wife

John Medling

7. Birth date of deceased (mo., day, yr.)

Sept. 6 19076.(c) If alive, give age.....83 years

8. AGE:

Years	Months	Days	If less than one day
19	9	11	hrs. min.

9. Birthplace

Georgia
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name.....Alfred McClain

13. Birthplace

Unknown

14. Maiden name

Estell Shroud

15. Birthplace

Essex, Fla.

16. Informant

Address

John Medling
Chesters Corn.

17.

(Burial, cremation, or removal. Which?)

To Mulville Funeral Home

Location

Waterbury, Connecticut

18. Funeral director

Address

Eda Patterson
Cerryville, Md.

19.

(Date rec'd by registrar)

19

June 3

19

47June E. Dougherty
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 30 1947 at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

Mitigation of Body

Due to.....

Due to.....

Aeroplane accident

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Accident Date of.....5-30-47Where did injury occur.....MD (City or town)..... (County)..... (State).....Injured at home, farm, industry, public place (where?).....Public CarrierMeans of injury.....Aeroplane Injured at work?.....

Medical Examiner

Secil County

23. SIGNATURE

John Medling M.D. or other.....John Medling
Address.....Forest St. Date signed.....5/31-47

43

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 4 1947

BUREAU 18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

CERTIFICATE OF DEATH

Reg. Dist. No. 0392796

1. PLACE OF DEATH

County Prince Georges
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 10 days
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Murray Miller

3. (b) Social Security Number

E 07

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Pauline Miller
7. Birth date of deceased (mo., day, yr.) May 10 1908 6. (c) If alive, give age 32 years

8. AGE: Years 39 Months 20 Days 20 If less than one day hrs. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Arshel Miller

13. Birthplace Russia

14. Maiden name Ester Sackman

15. Birthplace Russia

16. Informant Pauline Miller

Address 732 Penna Cr. Manassas

17. Removal Date thereof 6-4-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bldg. Fun. Parlor

Location Brooklyn N.Y.

18. Funeral director Lee A. Patterson

Address Quincyville, Md.

19. June 4 1947 Irene E. Daugherty
(Date rec'd by registrar) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Dauph.
City or town Manassas Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. 732 Pennsylvania Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47 at 6 42 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 18

Immediate cause of death Mutilated
Due to Body
Due to Airplane
Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results Physician: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5/30-47

Where did injury occur Port Deposit, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Carver

Means of injury Airplane Injured at work?

Medical Examiner Dr. Dodson
County Dauph.

23. SIGNATURE Dr. Dodson M. D. or other Dr. Dodson

Address Quincyville, Md. Date signed 6/4-47

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

98

RECEIVED
JUN 6 1947
BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 03928 96

1. PLACE OF DEATH:

County Berks
City or town Gettysburg Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death Sudden Landing
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State CONN. County HAMDEN
City or town 32 HALL STREET
(If outside city or town limits, write RURAL and give nearest town)
Street No. 32 HALL STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

HELEN Mary Elizabeth O'Brien

3.(b) Social Security Number

ED 7

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

OCT. 13 - 1922

8. AGE:

Years

Months

Days

If less than one day

24

7

17

hrs.

min.

9. Birthplace NEW HAVEN, CONN.

(Town, county, and state)

10. Usual occupation STEWARDESS

11. Industry or business AIR LINES

12. Name Mr. William H. O'Brien

13. Birthplace NEW HAVEN, CONN.

14. Maiden name Marechal

15. Birthplace BROOKLYN, N.Y.

16. Informant Records Eastern Air Lines

Address New York City

17. Removal Date thereof 6-4-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory M. F. WATKINS & SONS

Location NEW HAVEN, CONN.

18. Funeral director Per C. Patterson & Son

Address Poughkeepsie, N.Y.

19. Date rec'd by registrar June 4, 1947 Dr. E. Dougherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 80 1947 at 6:42 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Mutilation of body
airplane

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-30-47

Where did injury occur Gettysburg, Md (City or town) (County) (State)

Injured at home, farm, industry, public place, or elsewhere Public Car

Means of injury airplane Injured at work?

Medical Examiner Dr. Rodson or Cecil County

23. SIGNATURE Dr. Rodson M. D. or other

Address Wilmington Date signed 6-3-47

MARCPRESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

38

RECEIVED
JUN 6 1947
BUREAU V. H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County *Port Deposit Rural*
 City or town *Port Deposit Rural*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death *Sudden*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *N.Y.* County *Manhattan*
 City or town *New York*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *517 W. 161 St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Martin Percikorr

3. (b) Social Security Number

E07

4. Sex *M* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Jan 16 1907*
 B. (c) If alive, give age..... years

8. AGE: Years *40* Months *4* Days *12* If less than one day
 hrs. min.

9. Birthplace *Marsann Poland*
 (Town, county, and state)

10. Usual occupation *Pocket Book Maker*

11. Industry or business

FATHER 12. Name *Isaac Percikorr*
 13. Birthplace *Poland*

MOTHER 14. Maiden name *Malba Eisenland*
 15. Birthplace *Poland*

18. Informant *Henry Percikorr*
 Address *517 W. 161 St New York*

17. Removal Date thereof *6-4-47*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Guterman Funeral Home*
 Location *153 E. Broadway, New York City*

18. Funeral director *Lee C. Patterson & Son*
 Address *Queens, N.Y.*

19. *June 4* 19 *47* *Dr. E. D. Dugan*
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 30* 19 *47* at *6:42 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw h..... alive on 19.....

Immediate cause of death..... DURATION

Due to *Mutilation of body*

Due to *Airplane accident*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide *Accident* Date of *5/30-47*

Where did injury occur? *Port Deposit, Md.*
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Public Car*
 Means of injury *Airplane* Injured at work?

Medical Examiner *W. L. Dodson M.D.*
 Cecil County

23. SIGNATURE *W. L. Dodson M.D.* M. D. or other

Address *W. L. Dodson M.D.* Date signed *6-3-47*

24

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 6 1947
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03930

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH

County.....*Prince George's Rural*
 City or town.....*Port Deposit Rural*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death.....*Sudden Landing*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George S Pollitz Jr.

3. (b) Social Security Number

ED7

4. Sex.....*M* 5. Color or race.....*White* 6. (a) Single, married, widowed, or divorced.....*Married*
 6. (b) Name of husband or wife.....*Phyllis Pollitz*
 7. Birth date of deceased (mo., day, yr.).....*Dec. 31 1898* 6. (c) If alive, give age.....*50* years

8. AGE: Years.....*48* Months.....*4* Days.....*30* If less than one day.....*hrs.*.....*min.*

9. Birthplace.....*New York N.Y.*
 (Town, county, and state)

10. Usual occupation.....*Gravestone mender*

11. Industry or business.....

12. Name.....*Geo. S. Pollitz Sr.*

13. Birthplace.....*Germany*

14. Maiden name.....*Silma Randnitz*

15. Birthplace.....*Chicago Ill.*

16. Informant.....*Edward A Pollitz*

Address.....*180 E 39th New York N.Y.*

17. Removal.....*Removal* Date thereof.....*6-4-47*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Riverside Memorial Chapel*

Location.....*76th & Amsterdam Ave., N.Y.C.*

18. Funeral director.....*See A. Peterson & Son*

Address.....*Princeton, Md*

19. Date rec'd by registrar.....*June 4 1947* Registrar.....*James E. Dougherty*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....*Del.* County.....*Brownard*
 City or town.....*Holly wood*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.*1140 Jackson St.*
 (If rural, give LOCATION)

2. (g) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....*May 30* 19.....*47* at.....*6:20* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....*Fractured*

Due to.....*Body*

Due to.....*Asphyxiated*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....*Accident* Date of.....*5/30-47*

Where did injury occur.....*Port Deposit Md.*

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....*Public Carrier*

Means of injury.....*Carriage* Injured at work?

Medical Examiner.....*Cecil County*

Signature.....*Wang Sun Md* M. D. or other.....

Address.....*6-4-47* Date signed.....

RECEIVED

JUN 6 1947

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03931

CERTIFICATE OF DEATH

Reg. Dist. No.

94

1. PLACE OF DEATH:

County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? LIFETIME
 Hospital, institution, or street address where deceased died

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Cecil
 City or town North East Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Clinton White Turner

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Helen Walkey Turner
 7. Birth date of deceased (mo., day, yr.) Dec 2 1862 6.(c) If alive, give age _____ years
 8. AGE: Years 84 Months 5 Days 24 It less than one day _____ hrs. _____ min.

9. Birthplace Elk Neck Cecil Co Md
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Jefferson Turner
 13. Birthplace md
 14. Maiden name Rebecca Steele
 15. Birthplace md

16. Informant Marshall Turner
 Address North East Md

17. Burial Date thereof May 29-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Bethel
 Location Chesapeake City Rural Md

18. Funeral director Joseph R. Evans
 Address North East Md

19. 5-29- 1947 Lida Owens
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 8 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1947 to May 26 1947 and that I last saw him alive on May 26 1947

Immediate cause of death Myocarditis 1 yr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE O. B. Collins M. D. or other _____

Address North East Md Date signed 5-29-47

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JUN 3 1947

BUREAU C S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03933

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County... Cecil
 City or town... North East Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 1 year
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md County... Cecil
 City or town... North East
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Richardson

3. (b) Social Security Number

None

4. Sex... Male
 5. Color or race... white
 6. (a) Single, married, widowed, or divorced... widowed
 8.(b) Name of husband or wife... Effie Richardson
 8.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... About Dec 1870
 8. AGE: Years... about 70 Months... Days... If less than one day... hrs. ... min.

9. Birthplace... (Town, county, and state)
 10. Usual occupation... Laborer
 11. Industry or business
 12. Name...
 13. Birthplace...
 14. Maiden name...
 15. Birthplace...
 16. Informant...
 Address...

17. Burial Date thereof... May 14 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Charlestown Methodist
 Location... Charlestown Maryland
 18. Funeral director... Joseph R. Evans
 Address... North East, Md
 19. 5-14-1947 Lida & Owens
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 11 May 1947 at 8:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to 11 May 1947 and that I last saw him alive on 11 May 1947
 Immediate cause of death... Cerebral Thrombosis
 DURATION... 2 days
 Due to... Generalized Arteriosclerosis 5 years
 Due to... Hypertensive Cardiovascular Disease 15 years
 Other conditions... Benign Prostatic Hypertrophy
 (Include pregnancy within 3 months of death)
 Major findings of operations...
 Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury... injured at work?
 23. SIGNATURE... Klaus H. Huebner M.D.
 M.D. or other...
 Address... North East, Md Date signed... 11 May 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 17 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03934

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Steuir
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death Sudden Landing
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Costa Rica, Cent. Amer.
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Georgina Grillo Rivera

3. (b) Social Security Number

607

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single.

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 16 Months Days If less than one day hrs. min.

9. Birthplace Costa Rica
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Dr. Rafael Grillo

13. Birthplace Costa Rica

14. Maiden name Carmen Rivera Ortiz

15. Birthplace Costa Rica

16. Informant Joquin M. Gutierrez

Address 219 W. 80th St N.Y.

17. Removal (Burial, cremation, or removal. Which?) Removal Date thereof 6-7-47
(month) (day) (year)

Cemetery or crematory

Location San Jose, Costa Rica

18. Funeral director Lea D. Williams

Address Derbyville, Md.

19. June 7 19 47 Innocent E. Dunphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 30 19 47 at 6:42 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19 and that I last saw him alive on 19

Immediate cause of death

Capitulated body

Due to

Acrylonitrile

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30-47

Where did injury occur? Port Deposit Cent. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Carner

Means of injury Propane Injured at work?

Medical Examiner W. D. Cecil
Cecil County

23. SIGNATURE W. D. Cecil M. D. or other

Address Washington Md. Date signed 6-3-47

MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

48.

48

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JUN 11 1947

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03935 96

1. PLACE OF DEATH:

County Prince George's
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 1 year
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thelma Grillo Rivera

3. (b) Social Security Number

510

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years 15 Months Days If less than one day

9. Birthplace

Costa Rica
(Town, county, and state)

10. Usual occupation

11. Industry or business

Dr. Rafael Grillo

12. Name

Costa Rica

13. Birthplace

Carman Riveria

14. Maiden name

Costa Rica

15. Birthplace

Joquin M. Gutierrez

16. Informant

219 W. 80 St. N.Y.C.

17. Removal

San Jose, Costa Rica

18. Funeral director

Lee A. Patterson & Son

19. Address

Perryville, Md

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Levada, Central
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 173
(If rural, give LOCATION)
2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

Mutilated body

Due to

Airplane crash

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-30-47
Where did injury occur Port Deposit, Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Carner
Means of injury Airplane Injured at work?

23. SIGNATURE

W. L. Dodson Medical Examiner
Pring, Md Cecil County
M. D. or other
Address Pring, Md Date signed 6-3-47

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

UNITED STATES DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

3

RECEIVED
JUN 11 1947
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03936

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Phillip Rosengarten

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days.....
 If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....
 13. Birthplace.....

14. Maiden name.....
 15. Birthplace.....

18. Informant.....
 Address.....

17. Removal.....
 (Burial, cremation, or removal. Which?) Date thereof.....
 (month) (day) (year)

To Garretson Funeral Home
 Location.....
 Perth Amboy, New Jersey

18. Funeral director.....
 Address.....
 Perryville, Md.

19. Date rec'd by registrar.....
 (Date rec'd by registrar) 19. 47
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
 19. 47, at 642 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw him..... alive on.....
 19.....

Immediate cause of death.....
 Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide.....
 Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where).....
 Means of injury.....
 Injured at work?

23. SIGNATURE.....
 Address.....
 Date signed.....

Medical Examiner.....
 Cecil County
 M. D. or other
 Date signed.....

39

RECEIVED

JUN 4 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1642

03932

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH

County *Frederick*City or town *Fredericktown*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *17 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Pa* County *Cecil*City or town *Fredericktown*
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Francis Ross

3. (b) Social Security Number

*213-28-7965*4. Sex *M* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Isabel M. Ross*

7. Birth date of deceased (mo., day, year)

6. (c) If alive, give age *42* years

8. AGE:

Years *58*

Months

Days

If less than one day

hrs. min.

9. Birthplace

Camden, N.J.
(Town, county, and state)

10. Usual occupation

Boat Carpenter

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. May 19-47

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 16* 19*47* at *10:45* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Gun shot wound of head.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Suicide* Date of *5/15-47*

Where did injury occur?

Fredericktown

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) *Home*

Means of injury

Injured at work?

23. SIGNATURE

Address

Medical Examiner

For Cecil County

M. D. or other

Date signed *5/15-47*

MARGIN RESERVED FOR BINDING

VS AT5 9.45-15M

VS AT5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 21 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03937

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Bleed
City or town Fort Deford Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death Sudden Landing
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)
State N.Y. County New York
City or town New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 64 West 56 St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ricardo Lopez Rueda

3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 24 1924

8. AGE:

Years

23

Months

Days

6

If less than one day

hrs.

min.

9. Birthplace

Mexico

10. Usual occupation

Ballet Dancer

11. Industry or business

FATHER

12. Name

unknown

MOTHER

13. Birthplace

Senora Severa Lopez

14. Maiden name

Mexico

15. Birthplace

16. Informant

Address

Morgan Peck
64 West 56 St. N.Y.

17. (Burial, cremation, or removal. Which?)

Cremation

Date thereof

6-6-47

Cemetery or crematory

Greenmount Cemetery

Location

Baltimore, Maryland

18. Funeral director

Lu A. Patterson & Son

Address

Perryville, Md

19. (Date rec'd by registrar)

19. 47

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

June 6

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947 at 6:42 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw him alive on 19.

Immediate cause of death

Mutilation of body

Due to

Auto Plane

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 6-30-47

Where did injury occur? Fort Deford Cent. Ind. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Carver

Means of injury

Injured at work?

Plc Doctor Medical Examiner

23. SIGNATURE

Pranay Sen Md M. D. of other

Address Pranay Sen Md Date signed 6-7-47

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

33

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 9 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

03938

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Britt Rural
 (If outside city or town limits write RURAL and give nearest town)
 How long in above place of death Sudden
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State MD County Harford
 City or town Chesler & Head
 (If outside city or town limits write RURAL and give nearest town)
 Street No. 958 Grove St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henry Schifrin

3. (b) Social Security Number

ED7

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Gladys Schifrin

7. Birth date of deceased (mo., day, yr.)

Oct 13 1915

6. (c) If alive, give age

26 years

8. AGE:

Years

Months

Days

It less than one day

31718

hrs.

min.

9. Birthplace

Brooklyn N.Y.

(Town, county, and state)

10. Usual occupation

Attorney

11. Industry or business

FATHER

12. Name

Joseph Schifrin

13. Birthplace

New York N.Y.

14. Maiden name

Sophia Rosenberg

15. Birthplace

New York N.Y.

16. Informant

David Seid

Address

162-20 N. Hempstead

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

June 4 1947

Cemetery or crematory

Kirschenbaum Bros. Fun. Home

Location

345 Throop Ave. Brooklyn, N.Y.

18. Funeral director

Lee A. Patterson & Son

Address

Campville, Md.

19.

(Date rec'd by registrar)

19.

June 4 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Mutilated

Due to

Booby

Due to

Acrophane

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30-47

Where did injury occur?

Port Deposit, Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Car

Injured at work?

23. SIGNATURE

Chas. D. ...

M. D. or other

Address

...Date signed 6/3-47

4

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED
JUN 6 1947
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for corrections
shown on:

FILE No. G 116 JUN -2 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

How long in above place.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

KOSTAN SCHREIBER

4. Sex

M.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

II less than one day

55 ?

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

VIOLINIST

11. Industry or business

MOTHER

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address

17.....

(Burial, cremation, or removal. Which?)

Date thereof.....

JUNE 1, 1948

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19.....

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 30

1947

at 6:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

19.....

and that I last saw him..... alive on.....

19.....

Immediate cause of death.....

Mytilated body.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

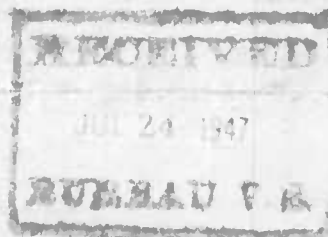
23. SIGNATURE.....

Address.....

Medical Examiner

M. D. or other

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:

County... Cecil
 City or town... near Rockes Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred:
 Earville,
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Cecil
 City or town... near Earville, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... R.D.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Wallace Scott

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M. Wh. Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 14, 1879

8. AGE: Years 67 Months 7 Days 2 If less than one day hrs. min.

9. Birthplace Germantown, Pa
(Town, county, and state)

10. Usual occupation Retd Farmer

11. Industry or business

12. Name Wm H. Scott

13. Birthplace Phila, Pa

14. Maiden name Martha Parr

15. Birthplace Phila, Pa

16. Informant Wallace Scott

Address 218. Hewett Road Lyco, Pa

17. Burial Date thereof May 19, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Laurel Hill

Location Phila, Pa

18. Funeral director H.W. Lippard

Address Elcton, Md

May 18 1947 J. R. P. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 May 1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 April 1947, to 16 May 1947 and that I last saw him alive on 16 May 1947

Immediate cause of death

myocardial failure

DURATION

1 day

Due to Acute Cardiac Dilatation

1 day

Due to Chronic Myocarditis

7 yrs 47

Other conditions Acute Insufficiency

7 yrs 47

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Allan R. Copenhaver M.D.

M. D. or other

Address Middletown, Del Date signed 46 Apr 47

CENTRAL OFFICE OF DEATH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

NOT A SUMMARY TABLE

RECEIVED
MAY 20 1947
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03940

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County... Cecil
 City or town... Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 5 mos. 28 days
 Hospital, institution, or street address where death occurred:
 Veterans Adm. Hosp., Perry Point, Md.
 How long in hospital or institution? Since July 27, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... North Carolina County... Davidson
 City or town... Thomasville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... c/o South Side Store
 (If rural, give LOCATION)
 2(a) If veteran, name war... Peace Time & WW-II

3. (a) FULL NAME

SEBASTIAN, Richard

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
 6. (b) Name of husband or wife --
 6. (c) If alive, give age -- years
 7. Birth date of deceased (mo., day, yr.) March 19, 1909
 8. AGE: Years 38 Months 1 Days 21 If less than one day hrs. min.

9. Birthplace... Thomasville, N.C.
 (Town, county, and state)
 10. Usual occupation... Textile worker
 11. Industry or business... Textile mills
 12. Name... Henry Clay Sebastian - deceased
 13. Birthplace... North Wilkesboro, N.C.
 14. Maiden name... Mary Combs - deceased
 15. Birthplace... Roaring River, N.C.

16. Informant... Brother, J.A. Sebastian
 Address

17. Burial Date thereof May 13, 1947
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery...
 Cemetery or crematory... Thomasville, North Carolina
 Location...
 18. Funeral director... FENNINGTON & SON
 Address... Havre de Grace, Md.

19. May 10 19 47 June E Dougherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 10 1947 at 12:10 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12, 1945, to May 10, 1947
 and that I last saw him alive on May 10, 1947

Immediate cause of death... Meningitis (acute cerebrospinal meningitis (not due to meningo-coccus) DURATION 1 day
 Due to...
 Due to...
 Other conditions... Lobular pneumonia Unknown
 Psychosis with syphilis of the central nervous system (Include pregnancy within 3 months of death) meningo-encephalitic type
 Major findings of operations...
 Date of op...
 Autopsy results... Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

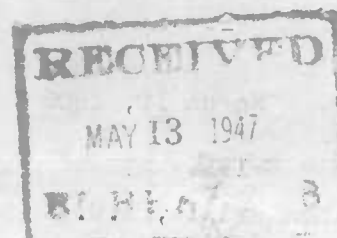
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... A. E. TROLLINGER, M.D., Clinical Director.
 Address... VAH, Perry Point, Md. Date signed... 5-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03941

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Putnam
City or town Putnam
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 10 days
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State NY County New York
City or town New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 210 Riverside Drive
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Elaine Sharretto

3. (b) Social Security Number

EDT

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1911

8. AGE: Years 35 Months 11 Days 19 If less than one day hrs. min.

9. Birthplace Reed Plantation, Inc.
(Town, county, and state)

10. Usual occupation Manicurist

11. Industry or business

12. Name David Bouchard

13. Birthplace Cape Lake, Inc.

14. Maiden name Jennie Spennie

15. Birthplace Michigan

16. Informant Elaine Driscoll

Address 6735 Ridge Blvd B

17. Removal (Burial, cremation, or removal. Which?) Removal Date thereof 6-4-47
(month) (day) (year)

Cemetery or crematory Universal Funeral Chapel

Location Lexington Ave. at 52 St., N.Y.C.

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. June 4 1947 Irene E. Dougherty
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 6420 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Mutilated body

Due to

Propane Gas

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date 5/30-47

Where did injury occur Putnam Co. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Car

Means of injury Airplane Injured at work?

Medical Examiner Dr. Doobson

23. SIGNATURE Dr. Doobson M.D. or other MD

Address Putnam Co. Md. Date signed 6-2-47

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14

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JUN 6 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03942

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Port Deposit Rural
 City or town Sudden Landing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Sudden Landing
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State N.Y. County New York
 City or town New York City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 34 W 18 St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Adelaide Solin

3. (b) Social Security Number

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 30 - 1907
 6. (c) If alive, give age..... years

8. AGE:

40

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Bayonne, N.J.

(Town, county, and state)

10. Usual occupation

Librarian

11. Industry or business

12. Name Max Solinsky
 13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal Date thereof 6-3-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Name of cemetery Ralph Fliedner Fun. Home
 Location Great Neck, Long Island, N.Y.

18. Funeral director

Address

19. June 3
 (Date rec'd by registrar)

19.

47James E. Langhorne

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 47 at 642 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Mutilated
body.
Crucifixion

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30-47
 Where did injury occur Port Deposit, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Medical Examiner W. D. O'Connell
 M. D. or other for Cecil County
 23. SIGNATURE W. D. O'Connell
 Address Port Deposit, Md. Date signed 6-1-47

3 4

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

03943

173

1. PLACE OF DEATH:

County Prince George's
 City or town Patuxent Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Sudden
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State N.Y. County New York
 City or town New York City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 84 W-10th St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cynthia Solin

3. (b) Social Security Number

ED7

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 6:42 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... to

and that I last saw him..... alive on

Immediate cause of death

Mutilated body
Acroplasmic acid

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of 7-30-47Where did injury occur? Patuxent Rural Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Will Dochoy M.D. Medical Examiner
Henry Ben M.D. M. D. or other
 Address 6-1-47 Date signed

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Feb. 23 1923

8. AGE:

Years

Months

Days

If less than one day

2437

hrs.

min.

9. Birthplace

New York City N.Y.

(Town, county, and state)

10. Usual occupation

Secretary

11. Industry or business

FATHER

12. Name

Max L. Solinsky

13. Birthplace

New York City

MOTHER

14. Maiden name

Ray Friedberg

15. Birthplace

Lebanon, Latvia

16. Informant

Lester L. Solin

Address

2589B Woke and Spring E

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Removal6-3-47

Place of removal

Ralph Friedner Fun. Home

Location

Great Neck, Long Island, N.Y.

18. Funeral director

Address

Lee A. Patterson & SonQuincyville, Md.

19.

Date rec'd by registrar

19

47June E. Daugherty

Registrar

35-

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JUN 4 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03944

96

1. PLACE OF DEATH

County.....
City or town.....
How long in above place of death.....
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

George Chambers Stavrett

3. (b) Social Security Number

E107

4. Sex.....
5. Color or race.....
6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days.....
If less than one day..... hrs..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....
13. Birthplace.....
14. Maiden name.....
15. Birthplace.....

16. Informant.....
Address.....

17. Removal..... Date thereof.....
(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory.....
Location.....

18. Funeral director.....
Address.....

19. June 16, 1947.....
(Date rec'd by registrar)..... Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
City or town.....
Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 30, 1947, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Date signed.....

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13

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JUN 9 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 039456

1. PLACE OF DEATH:

County Albany
City or town Port Jervis, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death Sudden
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State N.Y. County Albany
City or town Albany
(If outside city or town limits, write RURAL and give nearest town)
Street No. 748 Myrtle St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Arlene Sterenstern

3.(b) Social Security Number

807

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Herbert Sterenstern

7. Birth date of deceased (mo., day, year) unknown (1924)

8. AGE: Years 23 Months Days If less than one day
.....hrs.min.

9. Birthplace Albany N.Y.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Edward Lauterbach

13. Birthplace Germany

14. Maiden name Tessie Kolker

15. Birthplace New Jersey

16. Informant Judge Bookstein

Address 101 Eileen St.

17. Removal Removal Date thereof 6-4-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Silberg Memorial Chapel

Location 864 Madison Ave Albany, N Y

18. Funeral director Lee A. Patterson, Inc.

Address Perryville, Md.

19. June 4 19 47 Irma E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 30 19 47 at 6:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw himalive on19.....

Immediate cause of death

Mutilated body

Due to

Propane Gas

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 5/30-47

Where did injury occur Port Jervis, N.Y.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Carrier

Means of injury Propane Injured at work?

Medical Examiner Chas. L. Dodson, M.D. County Albany

23. SIGNATURE Chas. L. Dodson, M.D. M. D. or other

Address Perryville, Md. Date signed 6-2-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12.

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JUN 6 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County West
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Sudden Landing
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.Y. County Manhattan
 City or town New York
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 40 Central Park S.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Daniel Storch

3. (b) Social Security Number

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Dora Storch

7. Birth date of deceased (mo., day, yr.)

June 1 1894

6. (c) If alive, give age

50 years

8. AGE:

Years

Months

Days

If less than one day

(35)051130

hrs.

min.

9. Birthplace

Austria

(Town, county, and state)

10. Usual occupation

Manufacturer

11. Industry or business

MOTHER FATHER

12. Name

Daniel Storch

13. Birthplace

Austria

14. Maiden name

Sarah Semmel

15. Birthplace

Austria

16. Informant

Shirley Grossman

Address

Malverne L.I.N.Y.

17.

Removal

(Burial, cremation, or removal, Which?)

Date thereof 6-4-47

(month) (day) (year)

Cemetery or crematory

Riverside Chapel

Location

Far Rockaway, Long Island, N.Y.

18. Funeral director

See A. Patterson & Son

Address

Perryville, Md.

19.

(Date rec'd by registrar)

June 41947June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47June E. Dougherty47

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 301947

at

6420

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him

alive on

19

Immediate cause of death

Asphyxiation of
body.

Due to

Asphyxiation of

Due to

Asphyxiation of

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where)

Means of injury

Injured at work?

Medical Examiner

Signature

Allderson

Cecil County

Address

Keough

M. D. or other

Date signed

6-1-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

17

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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JUN 6 1947
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Cecil**
 City or town..... **Port Deposit**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **Life**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Cecil**
 City or town..... **Port Deposit**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Kate Morrison Strout

3. (b) Social Security Number

4. Sex..... **Female** 5. Color or race..... **White** 6.(a) Single, married, widowed, or divorced..... **Widowed**
 6.(b) Name of husband or wife..... **Theodore H. Strout**
 7. Birth date of deceased (mo., day, yr.)..... **March 28, 1856** 6.(c) If alive, give age..... years
 8. AGE: Years..... **91** Months..... **2** Days..... **1** If less than one day..... hrs. min.

9. Birthplace..... **Port Deposit, Cecil Co., Md.**
 (Town, county, and state)
 10. Usual occupation..... **House Wife**
 11. Industry or business.....

FATHER 12. Name..... **Hamilton Morrison**
 13. Birthplace..... **Penna.**
 MOTHER 14. Maiden name..... **Elizabeth Ulrick**
 15. Birthplace..... **Switzerland**

16. Informant..... **Mrs James Downs**
 Address..... **Port Deposit, Md.**
 17. Burial Date thereof..... **May 31, 1947**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **West Nottingham**
 Location..... **Colora, Md. Rural**

18. Funeral director..... **Lula Patterson & Son**
 Address..... **Ferryville, Md.**

19. **May 31, 1947** **Irma E. Daugherty**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **5-29** 19**47** at **4:15 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5-27 19**47** to **5-29** 19**47**
 and that I last saw him alive on **5-25-47** 19**47**

Immediate cause of death..... **Coronary Thrombosis** DURATION **72 hrs.**

Due to..... **Chronic Myocarditis**Due to..... **Sensitization**

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... **W. H. Richards, M.D.**Address..... **Port Deposit, Md.** Date signed..... **5-29-47**

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BUREAU V.S.

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47

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JUN 4 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03949

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Frederick Rural
 City or town Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Walden Landing
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Fla. County Dade
 City or town Miami Beach
 (If outside city or town limits write RURAL and give nearest town)
 Street No. 1037 Alton Rd.
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME

Michael Richard Stuart

3. (b) Social Security Number

4. Sex

M.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 28 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

12

hrs.

min.

9. Birthplace

Miami Beach Fla.
(Town, county, and state)

10. Usual occupation

child

11. Industry or business

FATHER

12. Name

Edward E. Stuart

13. Birthplace

New York City

MOTHER

14. Maiden name

Esther H. Rosenbarg

15. Birthplace

Jersey City, N.J.

16. Informant

Edward E. Stuart

Address

Miami Beach Fla.

17.

Removal
(Burial, cremation, or removal. Which?)

Date thereof

6-3-47
(month) (day) (year)

Name of funeral home

Guterman Funeral Home

Location

Jersey City, New Jersey

18. Funeral director

Lea Guterman & Son

Address

Perryville, Md.

19.

June 3 1947
(Date rec'd by registrar)James E. Dougherty
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 301947, at 6:42 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Asphyxiation of
body

DURATION

Due to

Due to

Other conditions

Airplane Accident

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/30-47
 Where did injury occur Port Deposit rural Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Airplane

Injured at work?

23. SIGNATURE

John D. O'Connor
 Address Rising Sun Md. Date signed 6/3/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47.9

RECEIVED

JUN 4 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

03950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Cecil Co.
 City or town Rising Sun Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland. County Cecil Co.
 City or town Rising Sun, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

James E. Taylor.

3. (b) Social Security Number

4. Sex male 5. Color or race white 8. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Elizabeth Taylor

7. Birth date of deceased (mo., day, yr.) April 5 1888 6. (c) If alive, give age 61 years

8. AGE: Years 6-9 Months 28 Days 28 If less than one day hrs. min.

9. Birthplace N. C.
 (Town, county, and state)

10. Usual occupation Farmers

11. Industry or business

12. Name William Taylor

13. Birthplace N. C.

14. Maiden name Martha Frances

15. Birthplace N. C.

16. Informant Elizabeth Taylor

Address Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 7, 1947
 (month) (day) (year)

Cemetery or crematory Baptist Cem

Location Conowingo Md.

18. Funeral director J. E. Tyson

Address Rising Sun Md.

19. (Date recd by registrar) May 5 1947 Registrar J. E. Tyson

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1947 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1946 to May 3 1947

and that I last saw him alive on May 3 1947

Immediate cause of death Chronic Dilatation of Heart

Due to Chronic Dilatation of Heart

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

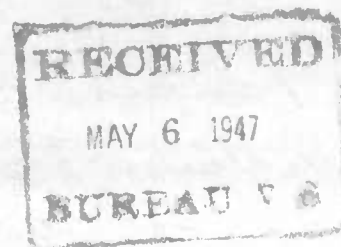
23. SIGNATURE J. E. Tyson M.D. M. D. or other

Address Rising Sun Md. Date signed 5/5/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03951

Reg. Dist. No. 96

1. PLACE OF DEATH: County..... <u>Cecil</u> City or town..... <u>Port Deposit</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>25 yrs.</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Cecil</u> City or town..... <u>Port Deposit</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Sarah Elizabeth Taylor</u>				3. (b) Social Security Number <u>May 6, 11-55 PM</u>			
4. Sex <u>Female</u>		5. Color or race <u>Colored</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Daniel Taylor</u>							
7. Birth date of deceased (mo., day, yr.) <u>June 6, 1903</u>							
8. AGE: Years <u>43</u> Months <u>11</u> Days <u>0</u> If less than one day hrs. min.							
9. Birthplace <u>Stauntonville, Augusta Co., Va.</u> (Town, county, and state)							
10. Usual occupation <u>House Wife</u>							
11. Industry or business							
FATHER		12. Name <u>Samuel Morton</u>					
MOTHER		13. Birthplace <u>Va.</u>					
14. Maiden name <u>Unknown</u>		15. Birthplace <u>Unknown</u>					
18. Informant <u>Isabel Taylor</u> Address <u>Port Deposit, Md.</u>							
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>May 9, 1947</u> (month) (day) (year) Cemetery or crematory <u>St. James</u> Location <u>Hayre De Grace, Md. Rural</u>							
18. Funeral director <u>Lea A. Patterson & Son</u> Address <u>Perryville, Md.</u>							
19. May 9 1947 (Date rec'd by registrar) Registrar <u>Irma E. Daugherty</u>							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>May 6 1947</u> at <u>11:55 P.M.</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 20, 1947</u> to <u>May 5, 1947</u> and that I last saw him <u>alive</u> on <u>May 5, 1947</u>							
Immediate cause of death <u>Chronic Myocarditis & Endocarditis</u>							
Other conditions <u>Chronic Nephritis</u>							
(Include pregnancy within 3 months of death)							
Major findings of operations Date of op.							
Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?							
23. SIGNATURE <u>B. J. Johnson, M.D.</u> Address <u>Port Deposit, Md.</u> Date signed <u>5/7/47</u>							

RECEIVED

MAY 12 1947

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

03952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex.....

5. Color or race.....

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

..... hrs.

min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

19. Date signed.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 30 1947, at 6:42 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19.....

to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address.....

Medical Examiner

Cecil County

M. D. or other

Date signed.....

157

RECEIVED
JUN 9 1947
BUREAU 7 B

V 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTE: There are 53 certificates of these deaths for 53 persons. PLUS this cer. for "one case of material . . . MARYLAND STATE DEPARTMENT OF HEALTH
unidentifiable parts . . . cremated 2411 N. Charles St., Baltimore 173
at Greenmount . . ." -quoted from **CERTIFICATE OF DEATH**
Dr. Dodson's letter 7-31-47 Gill - LL

03953

Reg. Dist. No. 96

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <i>Unidentifiable Tissue</i> (ONE BOX OF UNIDENTIFIABLE PARTS - cremated as below)				3. (b) Social Security Number <i>EDY</i>			
4. Sex <i>Female</i>		5. Color or race <i>White</i>		6. (a) Single, married, widowed, or divorced <i>Married</i>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <i>Army Lane</i>		6. (c) If alive, give age years		20. DATE OF DEATH <i>May 30 1947 at 6:48 PM</i>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19..... and that I last saw him alive on 19..... Immediate cause of death <i>Mutilation of bodies</i> <i>Airplane crash</i> Due to Due to Other conditions (Include pregnancy within 3 months of death)	
7. Birth date of deceased (mo., day, yr.)		8. AGE: Years Months Days If less than one day hrs. min.		9. Birthplace <i>Unknown</i> (Town, county, and state)		DURATION	
10. Usual occupation		11. Industry or business		12. Name		13. Birthplace	
14. Maiden name		15. Birthplace		16. Informant <i>Dr. Dodson</i> Address <i>Rising Sun Md.</i>		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE <i>Dr. Dodson</i> M. D. or other Address <i>Rising Sun Md.</i> Date signed <i>6/6-47</i>	
17. (Burial, cremation, or removal, Which?) <i>Cremation</i> Date thereof <i>June 6 1947</i> (month) (day) (year) Cemetery or crematory <i>Greenmount Crematory</i> Location <i>Baltimore, Md.</i>		18. Funeral director <i>Wes. Patterson & Son</i> Address <i>Berryville, Md.</i>		19. (Date rec'd by registrar) <i>June 6 1947</i> Registrar <i>Dr. Dodson</i>		20. (Date signed) <i>6/6-47</i>	

RECEIVED

JUN 9 1947

SURFACE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

03961

1. PLACE OF DEATH:

County Cecil
 City or town Ekhton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Union Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Ekhton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 283 Hollingsworth Manor
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Vadonis, Ray Wayne

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife.....

August 1946 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) August 1, 1946

8. AGE: Years Months Days If less than one day
9 19 hrs. min.

9. Birthplace Ekhton, Maryland
 (Town, county, and state)

10. Usual occupation infant

11. Industry or business.....

12. Name Raymond J. Vadonis

13. Birthplace Waterberry, Conn

14. Maiden name 42 brother, of thouse

15. Birthplace Perryville, Md

16. Informant Dorothy Vadonis

Address 283 Hollingsworth Manor

17. (Burial, cremation, or removal, Which?) Cremation Date thereof May 23, 1947
 (month) (day) (year)

Cemetery or crematory Salem

Location East Delaport Rd. Pund

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. May 21, 1947 Registrar J. H. Frazer
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 47 at 12 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 19 47 to May 20 19 47 and that I last saw him alive on May 20 19 47

Immediate cause of death:
 ① Presumably, P. lower lobe
 ② Diphtheria, severe type and
crisis
 Due to.....
 Due to.....

DURATION

8 days
4 days

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE S. R. H. Fraser, Jr., M.D.
 Address 233 E. Main St. Date signed May 21, 1947

RECEIVED
MAY 22 1947
BUREAU 68

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

03956

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... EssexCity or town... Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State... Baltimore County... EssexCity or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Irene H White

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 30 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Choked Body

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of... 5/30-47Where did injury occur? Essex (City or town) Essex (County) md (State)Injured at home, farm, industry, public place (where?) Route 40Means of injury Truck turned over Injured at work? yes

Medical Examiner

23. SIGNATURE Edw. J. ... Essex County

M. D. or other

Address... Essex Date signed... 6-3-476.(b) Name of husband or wife... Katherine Latham

7. Birth date of

deceased (mo., day, year)

B.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

49113

hrs.

min.

9. Birthplace.....

Norfolk, N.J.

(Town, county, and state)

10. Usual occupation.....

Truck Driver

11. Industry or business

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof... June 3, 1947

(month) (day) (year)

Cemetery or crematory.....

Clare Leaf Cemetery

Location.....

Woodridge, N.J.

18. Funeral director.....

Address.....

Elkton, md19. June 3

(Date rec'd by registrar)

19 47J. H. Frazer

Registrar

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03954

173

Reg. Dist. No. 96

1. PLACE OF DEATH

County

City or town

How long in above place of death

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

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MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Medical Examiner

M. D. or other

Date signed

18

RECEIVED

JUN 6 1947

BUREAU 78

V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03957

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
City or town Mary Perry Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs. 2 mos. 23 days
Hospital, institution, or street address where death occurred:
Veterans Adm. Hosp., Perry Point, Md.
How long in hospital or institution? Since Jan. 4, 1939

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt 15, Box 248
(If rural, give LOCATION)
2. (a) If veteran, name war WW-I

3. (a) FULL NAME

WISE, George N.

3. (b) Social Security Number

Unknown

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife --
6. (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 13, 1896

8. AGE: Years 51 Months 2 Days 16
If less than one day -- hrs. -- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Guard (Customs House)

11. Industry or business

12. Name George N. Wise - deceased

13. Birthplace Maryland

14. Maiden name Mary Ritz

15. Birthplace Maryland

16. Informant Hospital Records

Address

17. Removal Date thereof May 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Unknown

Location

18. Funeral director PENNINGTON & SON

Address Havre de Grace, Md.

19. May 20 19 47 June E. Smith
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 19 47 at 1:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 40 to May 29 19 47
and that I last saw him alive on May 29 19 47

Immediate cause of death Embolic phenomena, multiple DURATION 2 mos.

Due to Arteriosclerosis, generalized Unknown

Due to Hypertensive cardio-vascular renal disease Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations --

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE A. E. Trollinger

A. E. TROLLINGER, M.D., Clinical Director

Address VAH, Perry Point, Md. Date signed 5-29-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 31 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

03955

1. PLACE OF DEATH:

County... Cecil
City or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 years.
Hospital, institution, or street address where death occurred:
Union Hospital

How long in hospital or institution? 3/15/47 (2 Mo.)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Md. County... CecilCity or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)Street No. 227 E Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Harriet V. Walmsley

3. (b) Social Security Number

4. Sex

F.

5. Color or race

Wh.

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife...

April 21, 1889

7. Birth date of deceased (mo., day, yr.) April 21, 1887

8. AGE: Years 60 Months 0 Days 16 If less than one day
hrs. min.9. Birthplace... Buffalo, N. Y.
(City, county, and state)

10. Usual occupation... Housekeeper

11. Industry or business...

12. Name... John Walmsley

13. Birthplace... Maryland

14. Maiden name... Virginia Vickers

15. Birthplace... Virginia

16. Informant... Hospital Records

Address... Union Hospital, Elkton, Md.

17. Burial Date thereof May 10, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Elkton

Location... Elkton, Md.

18. Funeral director... H. R. Frazier

Address... Elkton, Md.

19. May 9, 1947 J. R. Frazier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1947, at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1925 to May 7, 1947
and that I last saw him alive on May 7, 1947

Immediate cause of death... Pulmonary Edema

DURATION

1 day

Due to Ludwig's Angina

1 wk

Due to...

Other conditions... Chronic Endocarditis
& Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings of operations...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. Heber... M. D. or other

Address... Elkton, Md. Date signed... 5/8/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 12 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03958

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Cecil

City or town Rural Earlville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

City or town Rural Earlville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 11 1882

8. AGE: Years 65

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 May 1947, at 2:30a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 May 1947 to 26 May 1947
and that I last saw him alive on 25 May 1947

Immediate cause of death

Carcinoma of the urinary bladder

DURATION

8 mo. 27

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Moons of injury

Injured at work?

23. SIGNATURE

Allan R. Cruckley

M. D. or other

Address

Middletown, Pa.

Date signed 28 May 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1947

BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03959

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? since 4/7/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Elkton Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 403 North St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary A. Warmkessel

3. (b) Social Security Number

4. Sex

F

5. Color or race

Wh.

6. (a) Single, married, widowed, or divorced

Single.

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Dec 24, 1866

8. AGE:

Years

Months

Days

If less than one day

80

4

14

hrs.

min.

9. Birthplace

Landingville Pa
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date read by registrar)

19 47

FR

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 19 47 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 22 to May 8 19 47

and that I last saw her alive on May 8 19 47

Immediate cause of death Central Embolus

DURATION

Due to Cardio renal

vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Elkton Md Date signed 5/8/47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 12 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03960

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital of Cecil County

How long in hospital or institution?

8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York CountyCity or town Yonkers
(If outside city or town limits, write RURAL and give nearest town)Street No. 19824 Carpenter Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Peter C. Wright

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Irene Wright

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

November 27 - 1870

8. AGE:

Years

Months

Days

If less than one day

7657

hrs.

min.

9. Birthplace

Merton, Wisconsin
(Town, county, and state)

10. Usual occupation

Retired clergyman

11. Industry or business

12. Name Charles Wright13. Birthplace Wisconsin14. Maiden name Phoebe Mead15. Birthplace Wisconsin16. Informant Mrs. Irene WrightAddress Hallas, New York17. Removal Date thereof May 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ImperialLocation Norwich, Conn.18. Funeral director St. PippinAddress Elkton, Md.19. May 5 - 1947
(Date rec'd by registrar)J.R. Frazer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from E.D.T.
.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

Medical Examiner

23. SIGNATURE P. E. Dodson of Cecil County

M. D. or other

Address Hallas, New York Date signed 5-4-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 6 1947